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ABSTRACT

Testimony concerned: (1) problems a high-risk, low-income mother had in receiving prenatal care; (2) dimensions of the infant mortality problem in Chicago, Illinois; (3) programs of the Illinois Department of Public Aid (IDPA) that address the problem; (3) the need for the IDPA to design a plan to implement SOBRA (the 1986 Sixth Omnibus Budget Reconciliation Act) and immediately begin providing medical assistance for prenatal care to all women whose family incomes fall below the federal poverty level; (5) dehumanization and other problems indigent pregnant women experience in accessing prenatal care programs; (6) fundamental causes of the inaccessibility of prenatal services to indigent women; (7) basic factors inhibiting the improvement of prenatal services; (8) the activities of the Infant Mortality Networks; (9) costs of malpractice insurance to physicians; (10) viewpoints and activities of the Chicago Urban League; (11) health issues in three predominantly Hispanic communities; (12) the influence of the level of malpractice insurance costs on service provision; and (13) the role of the churches in disseminating information about prenatal care. Materials in the record focus on viewpoints of the American Academy of Pediatrics, and a study of infant mortality bearing on the meaning of the concept "risk." A cost-effective strategy for providing medical coverage for uninsured pregnant women is included. (RH)

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THE CONTINUING INFANT MORTALITY CRISIS IN ILLINOIS

Part 2

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HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

HEARING HELD IN CHICAGO, IL, OCTOBER 5, 1987

Printed for the use of the
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THE CONTINUING INFANT MORTALITY CRISIS IN ILLINOIS

PART 2

MONDAY, OCTOBER 5, 1987

House of Representatives,
Select Committee on Children, Youth, and Families,
Chicago, IL.

The Committee met, pursuant to notice, at 2:42 p.m., at Children's Memorial Hospital, Chicago, IL, Hon. George Miller, Chairman, presiding.

Members present. Representatives Miller, Durbin, Coats, Hastert, and Hayes.

Staff present. Ann Rosewater, staff director; Karabelle Pizzigati, professional staff, Jill Kagan, professional staff; and Evelyn Anderes, minority staff assistant.

Chairman **Miller**. The Select Committee on Children, Youth, and Families will come to order.

This is the continuation of the hearing that started earlier this morning in Springfield on the continuing infant mortality crisis in the State of Illinois.

Today is National Child Health Day and while the White House is sending up balloons and saying proclamations, the Select Committee on Children, Youth, and Families is here to examine why the most preventable national tragedy, the annual death of 40,000 babies in the first 12 months of life, continues to occur. Thanks to my colleague, Richard Durbin, we have had the opportunity to come to Illinois, and spend the day looking at this crisis in Illinois. This morning we met in Springfield. This afternoon we are here in Chicago to examine the persistently high rates of infant death in this State.

Few indicators of a nation's health are more important than infant mortality. But after years of reducing infant deaths and low birthweight, a leading determinant of neonatal death and lifelong disability in the 1980's, our progress has come to a virtual halt.

In Illinois, there have been several exemplary State, city and private initiatives to improve infant health. Yet, infant mortality and low birthweight rates remain above the national average, and higher than in any other northern industrialized state. For Black infants in Illinois, and throughout the nation, the risks of infant mortality and low birthweight are twice as high as for white infants.

Since 1979, the percentage of pregnant women nationwide receiving prenatal care in the critical first trimester, 76 percent, has seen no marked improvement. A just released Government Accounting

Office survey of pregnant women, both Medicaid recipients and uninsured women, concluded that insufficient prenatal care was a problem for women of all childbearing ages, of all races, and from all sizes of communities. And GAO found that in Illinois and the seven other states surveyed, nearly two-thirds of the women received insufficient prenatal care last year. In Chicago, the rate was even higher, 72 percent.

This morning in Springfield, we heard that lack of services, inadequate health insurance, low physician reimbursement rates and high malpractice rates are the primary barriers to women receiving early and essential prenatal care.

In Chicago, however, even when services are available, we will learn that far too many low income women are not getting them. Lack of money to pay for services, lack of transportation, and child care, even among working families, means that thousands of women put off or do not get prenatal care. Others who may overcome these obstacles often face long waits in overcrowded clinics where highly stressed staff and language and cultural differences discourage consistent participation.

This afternoon we will hear, in depth, about the obstacles that Chicago women confront in their efforts to obtain prenatal care. We will hear from health care providers, state and local health officials, advocates and mothers who have had difficulty obtaining appropriate prenatal care. We will also hear concerns about the high postneonatal mortality rate in Chicago.

Let me thank Children's Memorial Hospital for their hospitality and for the opportunity to hold these hearings today. And I thank my colleagues, Dick Durbin and Dan Coats, from Illinois and from Indiana for their contributions to these hearings and the help that they have provided in the background work to set up today's hearings. I also want to send our thanks to the offices of Congressmen Rostenkowski and Sydney Yates for the support that they have provided to this Select Committee in arranging for these hearings.

At this point, I would like to recognize Congressman Coats.

[Opening statement of Hon. George Miller follows:]

Opening Statement of Hon. George Miller, a Representative in Congress From the State of California, and Chairman, Select Committee on Children, Youth, and Families

Today is national Child Health Day. And while the White House is sending up balloons and signing proclamations, the Select Committee on Children, Youth and Families is here to examine why a most preventable national tragedy—the annual death of 40,000 babies in their first 12 months of life—continues to occur. Thanks to my colleague Congressman Richard Durbin, we have had the opportunity to come to Illinois. This morning we met in Springfield, and this afternoon we are here in Chicago, to examine the persistently high rates of infant death in this state.

Few indicators of a nation's health are more important than infant mortality. But after years of reducing infant deaths—and low birthweight, a leading determinant of neonatal death and lifelong disability—in the 1980's, our progress has come to a virtual halt.

In Illinois, there have been several exemplary State, city and private initiatives to improve infant health. Yet, infant mortality and low birthweight rates remain above the national average, and higher than in any other northern industrialized state. For black infants in Illinois, and throughout the nation, the risks of infant mortality and low birthweight are twice as high.

It is deeply troubling that, over the past decade, on every measure—infant deaths, low birthweight, inadequate prenatal care, and births to teenagers—Chicago has surpassed the already high State rates. In 1985, the infant mortality rate for all Chicago babies was 16 per 1000 live births; for black Chicago babies, the rate was 22 per 1000, twice the rate for white babies.

What I find most disturbing is that a great many of these infant deaths—and, in fact, a great many problems in early childhood—could be prevented through early and continuing prenatal care. Yet an alarming number of women, especially those who are uninsured, low-income, or teenagers, fail to receive such care.

Since 1979, the percentage of pregnant women nationwide receiving prenatal care in the critical first trimester—76%—has seen no marked improvement. A just-released Government Accounting Office survey of pregnant women—both Medicaid recipients and uninsured women—concluded that "insufficient prenatal care was a problem for women of all childbearing ages, of all races, and from all sizes of communities."

And GAO found that, in Illinois and the 7 other states surveyed, nearly ⅔ of the women received insufficient prenatal care last year. In Chicago, the rate was even higher, 72%

This morning, in Springfield, we heard that lack of services, inadequate health insurance, low physician reimbursement rates and high malpractice rates are the primary barriers to women receiving early and essential prenatal care.

In Chicago, however, even when services are available, we will learn that far too many low-income women are not getting them. Lack of money to pay for services, transportation, and child care—even among working families—means that thousands of women put off or do not get prenatal care. Others who may overcome these obstacles often face long waits in overcrowded clinics where highly stressed staff and language and cultural differences discourage consistent participation.

Stopping these tragedies makes fiscal as well as human sense. From my perspective, the chance to spend $400 for comprehensive prenatal care over the 9 month course of pregnancy for a healthy baby instead of $20,000 for 20 days of neonatal intensive care for an underweight baby is an opportunity not to be missed. The evidence is clear: we can return $3 to the Federal treasury for every one we invest in nutrition supplements for high risk pregnant women, and more than $3 for every one we invest in prenatal care.

This afternoon, we will hear in depth about the obstacles which Chicago women confront in their efforts to obtain prenatal care. We will hear from health care providers, state and local health officials, advocates and mothers who have had difficulty obtaining appropriate prenatal care. We will also hear today concerns about the high postneonatal mortality rate in Chicago.

It is my hope that their testimony will help us determine how the federal, state and local governments, working together with the private sector, can overcome the barriers to care and ensure a healthy state for all children.

Let me thank Children's Memorial hospital for their hospitality and for the opportunity to hold our hearing here. I appreciate the excellent cooperation we have received from both the Governor and the Mayor in our planning of these hearings.

THE CONTINUING INFANT MORTALITY CRISIS IN ILLINOIS—A FACT SHEET

INFANT MORTALITY RATE CRITICALLY HIGH; ILLINOIS AMONG NATION'S HIGHEST

The U.S. ranked last (tied with Belgium, the German Democratic Republic and the German Federalist Republic) among 20 industrialized nations in its infant mortality rate (IMR)[1] in 1980–85. (Children's Defense Fund [CDF], 1987)

In 1985, there were 40,030 deaths of infants under 1 year nationwide, an IMR of 10.6. For white infants, the rate was 9.3 , essentially the same as in 1984; for black infants, the rate was 18.2, compared with 18.4 in 1984. (National Center for Health Statistics [NCHS], 8/87).

Neonatal mortality rates (NMR)[2] for all infants were essentially the same in 1984 and 1985 (7.0); postneonatal mortality rates (PNMR)[3] for white infants were about the same in 1985 (3.2) as in 1984 (3.3), continuing a 3-year pattern. For black infants, the PNMR declined between 1984 (6.5) and 1985 (6.1), continuing the decline observed from 1983 (6.8) to 1984. The downward trends in the NMR and PNMR have slowed recently for infants of both races. (NCHS, 8/87)

With the exception of Illinois, the 10 States with the highest overall IMR's in 1984 were southern (DC, SC, MS, AL, GA, NC, VA, LA, and TN). (CDF, 1987)

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[1] *Infant Mortality rate* (IMR) = deaths to infants under 1 year/1,000 live births.

[2] *Neonatal mortality rate* (NMR) = deaths to infants under 28 days/1,000 live births.

[3] *Postneonatal mortality rate* (PNMR) = deaths to infants 28 days-11 months/1,000 live births.

In 1986, Illinois had an IMR of 12.0, up from 11.6 the previous year. In 1984, the IMR for blacks (20.4) in Illinois was more than twice as high as that for whites (9.4). (Illinois Department of Public Health [IDPH], 1987)

LOW BIRTHWEIGHT RATE PLATEAUS; REMAINS STRONG PREDICTOR OF INFANT MORTALITY

Low birthweight (LBW)[4] infants in the U.S. are nearly 40 times more likely to die in the 1st month of life and are 3 times more likely to have neurodevelopmental handicaps and congenital anomalies than normal infants. (Institute of Medicine [IOM], 1985)

In 1985, 67% of infant deaths during the 1st month and 50% of deaths in the 1st year of life were attributable to LBW. (Government Accounting Office [GAO], 9/87)

In 1985, 6.8% of all live births (about 254,000 babies) were LBW, the same rate as in 1980. In Illinois, the proportion of LBW infants rose from 7.2% in 1982 to 7.5% in 1986. (GAO, 9/87; IDPH, 1987)

The proportions of very LBW[5] infants were higher in 1984 than in 1978 for both white and black infants. (NCHS, 12/86)

Of the babies born to Medicaid recipients and uninsured women recently surveyed by GAO, 12.4% were LBW. (GAO, 9/87)

Babies born to women who receive no prenatal care are 3 times more likely to be of LBW than those born to mothers who receive early care. (GAO, 9/87)

INFANT MORTALITY, LOW BIRTHWEIGHT MORE LIKELY AMONG BABIES OF TEENAGE MOTHERS

Infants born to teenage mothers are 60% more likely to die in the neonatal period and about twice as likely to die in the postneonatal period as those born to mothers over age 40. These infants are 2-3 times as likely to be LBW as infants born to mothers in their 20's or 30's. (Congressional Research Service, 1/86)

In 1984, 13% of all births were to teenagers. 13.6% of mothers under 15, 10.3% of mothers ages 15-17 and 8.8% of mothers ages 18-19 had LBW infants. (NCHS, 7/86; Select Committee on Children, Youth, and Families [CYF], 3/87)

In 1985, 12.5% of births in Illinois were to teenage mothers, 10.7% of whom had late prenatal care and 10.3% of whom had LBW infants. (IDPH, IL County Area Rates and Rankings, 1985)

While the average annual IMR among all Illinois women between 1982-84 was 10.0, it was 21.5 among 15-17 year olds and 17.4 among 18-19 year olds. (CYF, 12/85)

SMOKING AND ALCOHOL ABUSE PLACE INFANTS AT RISK OF DEATH, LOW BIRTHWEIGHT

In the U.S., maternal smoking results in roughly 50,000 fetal deaths and 4,000 infant deaths each year; about 36,000 (15%) LBW babies born in 1983 were underweight because their mothers smoked during pregnancy. (CYF, 5/86)

Between 3,700 and 7,400 babies were born with fetal alcohol syndrome (FAS) in 1982; 80% of children with FAS have pre- and postnatal growth retardation requiring neonatal intensive care. (CYF, 5/86)

PRENATAL CARE REMAINS UNAVAILABLE TO MANY

From 1979-1985, the proportion of mothers who did not begin prenatal care in the critical first trimester of pregnancy remained stagnant at 24%. 21% of white mothers and 38% of black mothers in 1985 did not receive early prenatal care. (NCHS, 7/87)

In Illinois, while there was a slight improvement in the proportion of women receiving prenatal care in the first trimester from 77% in 1982 to 78% in 1986, the percentage of women with very late or no care increased (4.3% in 1982 compared with 4.7% in 1986). (IDPH, 1987)

Approximately 11,400 low income women who receive late or no prenatal care deliver babies in Illinois each year. (Voices for Illinois Children, 8/87)

Nearly 63% of Medicaid recipients and uninsured women (69% of low-income teens) and 29% of women with private health insurance surveyed by GAO, received insufficient prenatal care. 16% of Medicaid recipients and 24% of uninsured women surveyed (but only 2% of privately insured women) began prenatal care during the last 3 months of pregnancy or made 4 or fewer visits. (GAO, 9/87)

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[4] *Low birthweight* (LBW) = 5½ lbs. (2,500 grams) or less at birth.

[5] *Very low birthweight* = under 3 lbs. 3 oz (1,500 grams) at birth.

In 1984, 17% of women of reproductive age lacked insurance to pay for prenatal care and another 9% had only Medicaid coverage. (GAO, 9/87)

In 1986, the average Medicaid reimbursement rate for total maternity care was about $473 nationwide and $446 in Illinois, while the median physician charge for such care was more than twice as high ($1,000). (GAO, 9/87)

A 1985 survey indicated that obstetricians/gynecologists (ob/gyn's) paid an average of $20,818 for insurance coverage in 1984. The mean cost of coverage in the Mid North region, which includes Illinois, was $23,025, or 11.1% of mean gross income. For those reporting increases, premiums had risen an average of $9,871 since 1983, and an average of $13,361 in the Mid North region. (American College of Obstetricians and Gynecologists [ACOG], 11/85)

As of 1985, 12.3% of ob/gyn's nationwide had given up obstetrics due to liability pressures. 23.1% had decreased the level of high risk obstetrical care and 13.7% had decreased the number of deliveries they performed. (ACOG, 11/85)

In 1984, an estimated 40% of high-risk pregnant women and children eligible for the Supplemental Food Program for Women, Infants and Children (WIC) were served; less than half (48%) of eligible Illinois women and children were served. (U.S. Department of Agriculture [USDA], 1987; CDF, 1987)

PRENATAL CARE, PROPER NUTRITION PROMOTE INFANT HEALTH, SAVE PUBLIC DOLLARS

A woman who has 13-14 prenatal visits has only a 2% chance of having a LBW baby. Without any prenatal care, the risk is over 9%. (GAO, 9/87)

WIC participation leads to longer pregnancies, leading to fewer premature births, and fewer fetal and neonatal deaths. For every $1 invested in WIC's prenatal component, as much as $3 are saved in short-term hospitalization costs. (USDA, 1/86; CYF, 8/85)

Every $1 spent on prenatal care for high-risk women could save $3.38 in the cost of neonatal intensive care, on which more than $2.4 billion is spent annually. (IOM, 1985; GAO, 9/87)

Mr. **Coats**. Thank you, Mr. Chairman. I do not have a formal opening statement. This is probably though, one of the most critical issues that the Children, Youth, and Families Committee has to deal with. And it is an area where, I think, by correct and timely intervention we can make a difference, and make a substantial difference. I look forward to hearing what the witnesses have to say, and I want to thank Congressman Durbin for his efforts in putting the Springfield hearing together. I also want to thank Congressman Hastert, who has been a valuable member of our Committee, translating his experience in the Illinois legislature to the efforts that he has made on behalf of the Children, Youth, and Families Committee in Washington. We thank him now for his efforts and participation in helping and urging us to come to Chicago for the hearing. So we look forward to the hearing and thank Children's Hospital for the chance to be here.

Chairman **Miller**. Thank you. Congressman Durbin?

Mr. **Durbin**. I want to thank Chairman Miller for bringing these hearings to Illinois. And unfortunately, it is a very important place to hold these hearings. I say unfortunately, because in the United States today, we rank dead last in the World among the industrialized countries in infant mortality.

As you look at the states across the nation you will find that the State of Illinois has the worst infant mortality rate of any northern state in the United States of America. And, I regret to add, that the City of Chicago has one of the worst infant mortality rates in our Country. So we have come to the source to explore the problem and try to work out solutions.

I might add that the testimony we received in Springfield suggests that these solutions will call on not only the federal government, but state and local government and the private sector as well if we are going to overcome this problem.

Infant mortality is a timely issue for anyone with a sense of compassion. This morning we walked through the neonatal care center in Springfield, Illinois. To find these tiny infants, no bigger than your hand, who are being kept alive by heroic efforts, but ladies and gentlemen, let me tell you, 60 percent of the infants in that neonatal care center were the children of Welfare mothers and mothers without insurance. Sixty percent. While only 8 percent of the population might fall into those categories. So we clearly see the need and the focus group we have to concentrate on to turn this around.

But it is also an issue for fiscal conservatives. Children are being crippled and diseased because of our neglect. Our neglect is causing human tragedy, and it is costing taxpayers of the United States and the State of Illinois millions of dollars, because of our neglect. We reimburse doctors about $450 for prenatal care and delivery of a child of a Medicaid mother. And yet, if we do not provide good care and access to care and as a result that child ends up in a neonatal care center, the cost to the taxpayer is at least $1,000 a day, for an average of about three weeks. And then that child, scarred by the experience, may have anything from blindness to mental retardation to grapple with the rest of its natural life.

I think this hearing addresses a really critical issue that really tests us and tests our government's ability to provide critical services. I thank Chairman Miller for bringing the Select Committee to Illinois. I would also like to commend my fellow colleague, Charlie Hayes, who has arrived.

Opening Statement of Hon. Richard J. Durbin, a Representative in Congress From the State of Illinois

First of all, I would like to take this opportunity to thank Chairman Miller and the Select Committee on Children, Youth and Families for holding this important field hearing. I would also like to thank the dedicated staff here at Children's Memorial Hospital for all their assistance in helping prepare for the hearing.

It is our aim today to explore some of the many factors that have contributed to the infant mortality crisis and barriers to prenatal care. I look forward to hearing testimony from our distinguished witnesses and thank all of you for joining us.

The U.S. infant mortality rate is a national crisis that extends far beyond local and state boundaries. Progress in reducing infant mortality in this country has come to a virtual standstill. America's infant mortality ranking among 20 industrialized nations has declined dramatically from 6th to a tie for last place. As our medical technology advances, our success rate in keeping babies alive is deteriorating at a shameful pace. Illinois is in the unfortunate position as one of the ten states with the highest infant mortality rate in the country. Illinois' low birthweight rate also above the national average.

The National Academy of Sciences has estimated that low-birthweight infants are 40 times more likely to die in the first year than other infants, and face a much greater risk of developing serious health problems and disabilities. The key to insuring the birth of a healthy baby is prenatal care. Pregnant women who receive no prenatal care are three times more likely to deliver a low birthweight baby than women who see a doctor early and regularly during their pregnancy. With good prenatal care, low birthweight births could be reduced by up to 15 percent, and an even higher percentage of birth defects could be prevented.

Earlier this morning, we visited the neonatal intensive care unit at St. John's Hospital in Springfield. While amazing advances in technology have allowed us to keep these tiny infants alive, they may be faced with long-term disabilities and may require special educational and social services throughout their lifetime. Caring for each child in a neonatal I.C.U. costs an average of $1,000 a day. More than $2.5 billion is spent annually on neonatal intensive care services in the United States.

These are shocking figures in light of the estimates that every dollar spent on prenatal care can save three dollars in the cost of caring for a low birthweight infant. Yet frequently in this country, we are finding that women are not getting the prenatal care essential for delivery of a healthy infant.

This national crisis clearly requires that our communities and our local, state and federal governments work together in order to turn the trend around. We owe our children a chance to begin a healthy, happy life.

Chairman MILLER. Thank you, Mr. Hastert.

Mr. HASTERT. Thank you, Mr. Chairman. It is a pleasure to be here today on this very serious issue. I look through this audience, and see people who I have worked with in the General Assembly through past years, and working on this very same problem. In this State, and in this City, there is a great population at risk a population who needs to be served better by the federal government and by the State government, and by the various local governments. We also have with us people who will testify from outside the City today, and from Kane County, which is in my District, they, too, have some serious problems. The second largest mortality rate in the State of Illinois, next to Cook County. So if we work together the State and local and private sectors, to try and find solutions to this problem, and basically that is why we are here. We are trying to find solutions. We are trying to work together, all levels of government are trying to find solutions to make this, again, the population at risk, infants, people who are working for people who are on Welfare and Medicaid, for them to work together so that they have an equal chance in this State and this Nation. And we have some very important people to testify before us today. So without any further ado, Mr. Chairman, I look forward to hearing them speak.

Chairman MILLER. Thank you very much. Congressman Hayes?

Mr. HAYES. Thank you, Mr. Chairman, I certainly agree with my colleagues who just spoke. You have got some important people to testify before this Committee, and I just want to commend you for bringing this hearing into Chicago, dealing with what I consider to be a real important issue, the mortality rate crisis that exists in Chicago among our children. And I just wanted to drop by and with my presence acknowledge my congratulations to you for taking the time out. I know you have got busy schedules to come into our City here, and welcome you here.

Many of these kids that you talk about who are suffering from mortality are residents of my District, and I want to say to you thank you for coming, and I know you will get some good testimony from the witnesses supporting the need for you being here, and the need for federal action in this whole area.

And I thank you and my colleagues for you being here in Chicago, the greatest city in the Country.

Chairman MILLER. Well, we are not here to debate that, Congressman.

The members of the first panel this afternoon will be Emma Scott, who is a parent from Chicago; Dr. Lonnie Edwards, who is the Commissioner of the Chicago Department of Health in the City of Chicago; Edward Duffy, who is the Director of the Illinois Department of Public Aid; Jerome Stermer, who is the President of Voices for Illinois Children, and Jennifer Artis, who is the President of Healthy Mothers and Healthy Babies Coalition from Chicago. If they would come forward, please, and come up to the witness table. Your written statement will be placed in the record in its entirety, and the extent to which you can summarize, or just hit the high points of your testimony that you want the Committee to be aware of, will be appreciated. We are under some time constraints, but we want to make sure that you each have a full opportunity to testify and to provide some time for the members of the Committee to ask you questions.

Ms. Scott, we will start with you first. If you can pull the microphone a little bit closer to you. And thank you very much for being with us this afternoon.

STATEMENT OF EMMA SCOTT, A PARENT FROM CHICAGO, IL

Ms. Scott. Thank you. My name is Emma Scott. I am age 32, I have four children, and I am married.

I had my last child at the County Hospital. Because I had no money, no green card, and I had no medical insurance, other hospitals would not accept me. I know, because I tried, so I went to my neighborhood Board of Health. They told me that I was a high risk patient and I needed to go to the Cook County high risk clinic. So I made an appointment. The appointment took me one month. It took me one hour to get there and two trains, and when I first got to the clinic, I thought every pregnant woman in Chicago was in that room.

In the clinic, I would wait in line with about 20 to 30 other women just to turn in my urine. That was not to see the doctor. Then I would be there at 9:00, I would not leave until 4:00. The thing I really hated about my prenatal care at Cook County was that I had a different doctor every time I went. It made me feel like I had no privacy. One day I asked the social worker for carfare. She gave me carfare home and told me that carfare was for extreme emergencies. I am the mother of four children, and I need carfare, when I am going someplace like that every day of the week I was going there.

During my stay at the hospital, which lasted abour 14 days, I shared a ward with 25 other women, and my bed was like 50 steps to the bathroom both ways. The bathroom had one shower, no tub, and three commodes. Imagine having to use the bathroom during visiting hours, when there are all these men, and you are sick and about to have a baby, and have to walk down the aisle past these people.

But all in all, ladies and gentleman, my baby is a girl. She is the only baby girl in my family. She weighed 3 pounds, 15 ounces at the time, and I am very grateful to the doctors for their care.

And I thank you for your time and your attention.

[Prepared statement of Emma Scott follows:]

PREPARED STATEMENT OF EMMA SCOTT, CHICAGO, IL

Ladies and Gentlemen:

My name is Emma Scott. I am age 32, I have four children, and I'm married.

I had my last child at Chicago Cook County Hospital. Because I had no money, no Green Card, and no medical insurance, other hospitals would not accept me. I know because I tried, so I went to my neighborhood Board of Health. They told me there that I was a high-risk patient and needed to go to the high-risk clinic at Cook County, since no other hospital would accept me. My first appointment took a one month wait. It takes me one hour to get there and two trains and when I first got to the clinic, I thought every pregnant woman in Chicago was in that room, for a moment.

But in the clinic I would wait in line with about 20 to 30 other women just to pass in my urine. One thing that I really didn't like about my pre-natal care was that I had a different doctor each visit, and it made me feel like I had no privacy. I was very displeased with my pre-natal care.

My appointments would be at 9:00 a.m. and most time I still be there at 4:00 p.m. One day I asked the social worker about carfare. She gave me fare one way and told me that carfare was for extreme emergency. I never asked again but I needed carfare.

During my stay at the hospital which lasted about 14 days, I shared a ward with about 25 other women and my bed was like 50 steps to the ladies rooms both ways. The bathroom only had one shower, no tub, and three commodes. Imagine having to use the bathroom during visitor hour. I'm really glad that I was able to have my other babies someplace nice. But, in all, ladies and gentlemen, my baby is the only girl in my family. She weighed 3 lbs., 15 oz. I am grateful for the doctor's care.

Thank you for your time and attention.

Chairman MILLER. Thank you, Mr. Edwards?

STATEMENT OF LONNIE C. EDWARDS, M.D., COMMISSIONER, CHICAGO DEPARTMENT OF HEALTH, CHICAGO, IL

Dr. EDWARDS. Thank you. Good afternoon, distinguished members of Congress, participants, and interested observers.

I am pleased to have this opportunity to paint you a picture of the infant mortality problem in Chicago, and a more comprehensive written testimony you have before you. I intend to just present some of the most salient points at this time.

During the first term of Mayor Harry Washington, significant progress has been made in reducing infant mortality—in reducing the infant mortality rate here in Chicago. The trend from 1982 to 1986 indicated over an 11 percent decline in infant mortality, from 18.6 to 16.5, infant deaths per 1,000 live births. Of these statistics, the Chicago Black infant mortality had declined 10.5 percent since 1982.

As part of our attempts, in spite of declining resources, a mayoral committee on infant mortality was established. The number of public health nurses increased, as well as an increase in city dollars invested in attacking the problem.

But despite our progress, we are far from pleased at the rate remaining too high. We are also aware that other cities across the Country have experienced what appears to be a plateauing in infant mortality, and have actually seen that infant mortality rise after years of steady decline, and several have infant mortality rates that now exceed the Chicago rate.

Progress in reducing Chicago's infant mortality rate have been made in the reduction of the neo-mortality rate. In the last ten years, the neo-mortality rate has decreased over 40 percent, while the post-neonatal rate declined less than one quarter. In the last five years, Chicago's post-neonatal rate has remained startling high, reflecting the seriousness of the problem we face today.

Despite the fact that Chicago's Black infant mortality rate has declined 10.5 percent since 1982, there is great disparity between Black and White rates of infant mortality. Chicago Black infants die at twice the rate of Chicago's White infants, almost 22 of every 1,000 rates dying in 1985.

The difference is greater in the post-neonatal period, where almost three times as many Black babies die in Chicago as White babies the same age.

Teen pregnancy and parenthood, another factor, is often the beginning of the perpetuating cycle of poverty and dependence which can affect infant mortality for generations and generations to come.

The delivery of health care and social services, socioeconomic conditions, and the lifestyles of our citizens all contribute to Chicago's infant mortality rate. Most critical is poor financial, geographic psycho-social and cultural access to quality health care. Particularly prenatal care.

Nearly 23 percent of Chicago's women received inadequate prenatal care in 1984 due to lack of money. Public assistance grants are simply inadequate to cover all women who are in need of financial assistance, and Medicaid eligibilty is extremely restrictive covering only the most impoverished Chicagoans.

Expansion is unlikely. In addition, up to 20 percent of Chicagoans are completely without health insurance coverage of any kind. The excellent statewide prenatal system has been compromised because of the lack of adequate financial reimbursement for mothers and infants served through any of the available insurance coverage.

The increase in the number of uninsured pregnant women—recent changes in reimbursement for hospital care, and the access of a system to subsidize the cost of our health care has substantively barred many high risk women from a central perinatal network services.

These are the problems that we face. And while Chicago has been fighting infant mortality for a decade, local efforts have been intensified. The past four years was significantly increasing city funding and at the core of this effort is Chicago's Department of Health network of neighborhood health centers. Maternal and child clinics and mental health clinics, whose efforts in serving Chicago's poorest mothers and infants are coordinated under the Department's comprehensive maternal and child health programs.

This intensification has included a near doubling of public health nursing, despite the nationwide nurse shortage, and limited resources. Other strategies are also being pursued to increase the number of nurses.

Chicago has also initiated the infant mortality reduction initiative, a comprehensive infant mortality program to address the problems we face, given the resources we have available.

Mayor Harry Washington has appointed an advisory committee on infant mortality to assist in marshalling resources city-wide, and in recommending roles that both public and private organizations should play in this effort.

The advisory committee and the Chicago Department of Health recently developed a strategic plan for infant mortality reduction. For the extent of reduction for the city's effort, the plan also is intended to address the complexity of the infant mortality problem, which has been caused by misunderstandings of the part—on the part of the general public, and by the attempt by some for overly-simplistic solutions.

The complexity of the infant mortality lies in the integral relationship of the problem to the health and lifestyles of individuals intertwined with socio-economic environments of a community.

For example, the influence of drugs, the influence of alcohol is seldom considered significant. Yet, the effects on maternal health and child health can be profound. Likewise, the withdrawal of funding from the social service systems of a community reaches down to the individual mother, and that infant.

Thus, the problem must be considered from a comprehensive perspective, that of the synergy at work.

A special committee on socio-economic issues has been established, to focus the attention on the full mayorial advisory committee on this aspect of the problem.

The cornerstone of the infant mortality reduction initiative is the community network of local agencies and organizations who can provide a full range of services to their area residents, including Outreach activities, case management, tracking, and follow-up. Also, assistance in securing needed social services, housing assistance, mental health and substance abuse counseling, and also child care.

You will hear more about this from others who will testify here today.

A second program designed to increase access to high quality inpatient obstetric care for the medically indigent, is the Partnership in Health with Hospitals program. Partnership in Health is a cooperative arrangement between selective Chicago-area hospitals and the Chicago Department of Health, which links the obstetric patient at Chicago Department of Health clinics with a specific, quality hospital, providing a prearranged minimum amount to the hospital as payment for the delivery and after delivery, the patient is referred back to the clinic for post-neonatal care. The rate includes two prenatal visits and two postnatal visits.

This program will help reduce the infant mortality rate by minimizing the number of mothers who receive no prenatal care, reducing the women using hospital emergency rooms for delivery, and by providing continuity throughout the pregnancy and the infancy period.

A Partnership has also been established with religious leaders across the city to enlist their support in raising the awareness of the community concerning infant mortality and the services that are available to the members of their congregation. Several obstacles exist to successful implementation and further progress in infant mortality reduction.

Insufficient resources hamper all efforts, and while all levels of government must examine their priorities, and resource allocation decisions, more federal and state money is needed to fund medical care for the poor, to continue and expand the WIC program, and to expand the program funded under the MCH Block Grant.

Greater coordination of the various enabling programs must begin at the federal level and expand to all levels of government. Cutbacks in federal government programs, such as the community development block grant, and general revenue sharing, have further contracted the dollar availability to the city for public health programs.

And finally, the overall lack of understanding of the socioeconomic nature of infant mortality must be corrected. Reduction of infant mortality is not a national priority, and must become one, on par with other grave national problems.

Thank you, gentlemen.

[Prepared statement of Lonnie Edwards, M.D., follows:]

Prepared Statement of Lonnie C. Edwards, M.D., Commissioner, Department of Health, Chicago, IL

For decades, Chicago has had one of the highest infant mortality rates of the nation's large cities. During the first term of Mayor Washington, significant progress has been made. From 1982 to 1986, Chicago experienced an 11% decline in infant mortality, from 18.6 to 16.5 infant deaths per 1,000 live births. As part of these statistics, the Chicago Black infant mortality rate has declined 10.5% since 1982. As part of our attempts, in spite of declining resources, a Mayoral committee on infant mortality was established, the number of public health nurses increased, along with an increase in City dollars invested to attack this problem.

Infant mortality remains one of the most serious public health problems facing Chicago today and despite our progress, the current rate is unacceptably high. We are also aware that large cities across the country have experienced what appears to be a plateauing in infant mortality. Some cities have actually seen their infant mortality rates rise after years of steady decline; several now have infant mortality rates that exceed Chicago's rate. Even at the current level, Chicago's infant mortality rate is below that of several other Illinois cities whose population characteristics would not suggest such high rates of infant mortality. Clearly this is a problem of national proportions.

Infant mortality has two components: neonatal mortality, or deaths to infants under 28 days, and postneonatal mortality, or deaths from 28 days to one year. Neonatal mortality is more reflective of the mother's health and the medical care she receives while she is pregnant; postneonatal mortality is more reflective of environmental conditions as well as parenting skills and the medical care the child receives.

Much of the progress in reducing Chicago's infant mortality rate has been made in the reduction of neonatal mortality. In the last ten years, the neonatal mortality rate has decreased almost 40%, while the postneonatal rate declined less than one-quarter. In the last five years, Chicago's postneonatal rate has remained virtually unchanged, reflecting the seriousness of the problem we face today.

Despite the fact that Chicago Black infant mortality has declined 10.5% since 1982, there is great disparity between Black and White infant mortality rates. Chicago Black infants die at twice the rate of Chicago White infants, almost 22 of every 1,000 black babies dying in 1985. The difference is greatest in the postneonatal period when almost three times as many Black babies die in Chicago as White babies the same age.

A major contributor to infant mortality is low birthweight. In contrast to declines nationally, Chicago's rate of low birthweight has remained around 10% for the last 20 years. Black infants are two times more likely to be born low birthweight as White babies born in Chicago.

Teenage pregnancy is another factor to consider in the infant mortality problem. Biologically, teens face a slightly greater risk for infant mortality: in 1985, Chicago teens accounted for 20% of all births but almost one-quarter of all infant deaths. However, the major risk of teen pregnancy goes beyond today's infant mortality rate. Teen parenthood is often the beginning of a perpetuating cycle of poverty and dependency which can affect infant mortality for generations to come.

Contributing Factors

Several factors involving the delivery of health care and social services, socioeconomic conditions, and the lifestyle of our citizens influence Chicago's infant mortality rate.

Poor access to quality health care services is one of the major contributing factors to infant mortality. Access has three components: financial, geographic, and psychosocial or cultural.

Of primary importance is access to prenatal care. To be comprehensive, prenatal care should include related services such as nutrition, mental health and substance abuse counseling and health education. Just as critical is access to care throughout a woman's reproductive cycle, including services needed prior to conception such as primary care, family planning, nutrition, mental health and substance abuse counseling, and care after the child is born for the continued health of both the mother and the infant.

Nearly 23% of Chicago women received inadequate prenatal care in 1984. The primary barrier to accessing prenatal care is lack of money. Public assistance grants are simply inadequate to cover all women who are in need of financial assistance. Medicaid eligibility is extremely restrictive, covering only the most impoverished Chicagoans.

Illinois has historically been reluctant to expand Medicaid coverage to women who fall below the poverty level but above the income requirements for public assistance. Legislation now awaiting the Governor's signature may begin to address this issue. This legislation, if signed, will expand benefits to cover prenatal and early infant care to women whose incomes are below the federal poverty level but above Illinois' AFDC eligibility levels. The governor's action is uncertain given the state's current fiscal situation.

In addition, up to 20% of Chicagoans are completely without health insurance coverage of any kind. Many of these persons are employed in low-paying or part-time jobs and cannot afford out-of-pocket health care health expenses.

Other problems are significant barriers to accessing prenatal care.

- Lack of personal transportation and long travel times to health care sites cause many women to delay care until ready to deliver, often using hospital emergency rooms for labor and delivery.
- Cultural barriers and health care providers who do not speak the language of their patients are major detriments to consistent care.
- Psychological and educational barriers keep women from recognizing the importance of early and comprehensive prenatal care.
- Lack of adequate funding for health care providers, particularly for those in the public sector who are the primary providers of care for the poor, has led to overburdening of staff and long delays for appointments as well as lengthy waiting times in clinics and offices.
- Inadequate numbers of public health nurses, proven to be one of the most important interventions in reducing postneonatal mortality, has hampered outreach activities. More public health nurses are needed to identify the pregnant women in need of services, act as case managers, and provide needed services in their homes.
- The maldistribution of health care resources has left many areas of the city without adequate numbers of physicians. Most of Chicago's West Side and large portions of the South Side have been designated as Health Manpower Shortage Areas, and these are the areas with the highest infant mortality rates.
- Access to prenatal care alone is not enough - the care provided must be quality care. Beyond the care provided by

the perinatal system, Chicago Department of Health facilities and other institutional providers, the quality of the prenatal care provided to women in Chicago is unknown. Financial pressures and competition throughout the City has forced many providers to cut corners to stay afloat, therefore many women may not be receiving the intensity of care needed to deliver healthy babies in a high risk setting.

Socioeconomic factors contribute to Chicago's infant mortality problem, since a high infant mortality rate is a symptom of the overall socioeconomic dynamics of a community. Poverty is the strongest correlate of infant mortality.

Today's technology can save more medically high risk infants than ever before in history, but these infants are being discharged to impoverished families who don't have financial resources or necessary support. The pervasive high rate of postneonatal mortality, especially among Chicago's disproportionately poor, Black community, is reflective of the lack of progress being made to improve the character the environment these infants are being sent to live in.

Inadequate public assistance levels, unrelenting unemployment and low-paying jobs plague our City. The percentage of Chicagoans living below the poverty level increased over 6% between 1970 an 1980 compared to a national decrease of almost 1%. And, in those Chicago communities with the highest infant mortality rates have an average of 39% of persons living below poverty compared to 20% citywide and a national average of 12%.

Other factors, all highly associated with poverty and interrelated, are major risk factors for infant mortality. These factors especially affect infants in the postneonatal period:

- Unsafe housing conditions, exacerbated by overcrowding, have a direct impact on the health of a child. Chicago does not have a sufficient number of affordable housing units for low-income residents.

- High drop-out rates and poor quality education create parents who are poorly equipped to support and care for infants.

- High unemployment and insufficient job training hampers adults from finding employment that will lead to life-long self-sufficiency.

The stresses of unrelenting poverty represent a third set of factors contributing to our infant mortality problem. Low income women are less likely to adopt healthy lifestyle changes during their pregnancies, and poor nutrition, alcohol and drug abuse significantly increase risks for infant mortality.

Almost half of all the babies born in Chicago last year were to unmarried women, the majority of whom live in poverty. The stresses of being sole caregiver and financial support for their families increases the potential that unborn children will be unwanted, and that newborn children will be abused and neglected.

Recent Perinatal System Problems

The regionalization of health care delivery to high risk and at risk pregnant women throughout pregnancy, at delivery, and after delivery, and care to their infants has provided the most dramatic reduction in infant mortality over the past decade. This system of perinatal care is part of the very foundation of public health's strategy to reduce infant mortality.

This proven strategy of Perinatal Regionalization will only continue to work if those at risk for poor outcomes are able to access the appropriate levels of care. Six of the state's 10 perinatal networks are in the Chicago area. Networks are comprised of hospital centers offering the most specialized care to high risk mothers and infants. These perinatal centers preside over less specialized hospitals providing intermediate and primary care. Formal agreements exist between a center and its network hospitals for consultation, transfers, and transporting sick mothers and very tiny and sick infants.

This excellent system is compromised because of the lack of adequate financial reimbursement for mothers and infants served through any of the available insurance coverage mechanisms. Funding from Federal programs is not intended to cover direct patient services, leaving the Medicaid system or other special State programs as the major source of reimbursement for low-income utilizers of the perinatal system. It is not surprising that women who are at greatest risk for adverse pregnancy outcome are poor. The increase in the number of uninsured pregnant women, coupled with the absence of a system to subsidize the cost of their health care has functionally barred many high risk women from essential perinatal network services.

A recent Chicago study uncovered a phenomenon called "patient dumping." Dumping is defined as "the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere." A second study involving emergency department transfers to the Cook County Hospital discovered that patients transferred were predominantly Black or Hispanic, were predominantly unemployed, and were usually transferred because they lacked adequate health insurance. This phenomenon of dumping patients has had major financial implication upon public hospitals. It is estimated by

Cook County Hospital that such transfers in 1983 resulted in an estimated $24.1 Million in uncompensated care.

Although federal legislation has existed since August 1, 1986 which imposed penalties for "dumping", this has not protected high risk pregnant women. The high risk maternal patient distribution across our city demands an equitable distribution of incurred expense while delicately balancing the effort with the appropriate level and quality of care. It is clear that these facilities cannot bear the total financial burden for providing largely unreimbursed care to uninsured high risk pregnant women.

Under recent reimbursement strategies in Illinois, inpatient days alloted for Public Aid recipients were shifted from teaching hospitals to community hospitals. At the same time, "high risk" patient days were excluded from the shift under the classification of "Special Care Days". However, the number of "Special Care Days" is insufficient to reimburse hospitals including perinatal centers for the special care volume that they are expected to provide. The result is that perinatal centers often exhaust their "Special Care Days" before the end of the fiscal year and must either absorb the additional cost or transfer the patient to a hospital with remaining "Special Care Days". As the shortage is system-wide, a large disproportionate share of the transfers are made to Cook County Hospital.

An additional category of difficulties has grown out of the attempted solutions. Limitations on available "Special Care Days", the limited capacity of the private and not-for-profit hospitals, and the continued growth of the under and uninsured all contribute to barriers to appropriate care. In the midst of all of these complications lies the undeniable element of poverty.

Chicago Initiatives

While Chicago has been fighting infant mortality for decades, local efforts have been intensified the past four years. At the core of this effort is the Chicago Department of Health network of neighborhood health centers, maternal and child clinics and mental health clinics, where service to Chicago's poorest mothers and infants is coordinated under the Department's comprehensive maternal and child health program. This intensification has included a near doubling of public health nurses despite the nationwide nurse shortage and limited local resources. Other strategies to increase the availability of public health nurses in areas of greatest need are being pursued such as the development of an allocation formula to accurately predict an area's need for public health nurses based on multiple factors.

Chicago has also initiated a comprehensive infant mortality program to address the problems we face given the resources we have available. Mayor Harold Washington has appointed an advisory committee on infant mortality to assist in marshalling resources city-wide and in recommending roles that both public and private sector organizations should play in this effort.

The Infant Mortality Reduction Initiative represents our integrated approach to attacking the infant mortality problem. The IMRI model recognizes that to fight infant mortality, community mobilization involving more than the health care community is a minimum requirement.

The cornerstone of the Infant Mortality Reduction Initiative are Community Networks. One agency in each community, the Community Network Coordinating Entity (CNCE) is responsible for coordinating a number of local agencies and organizations who can provide a full range of services to their area residents. The services required go beyond medical care, and include:

- Outreach activities to identify those in need.
- Case management to assist families negotiate the imposing and unwieldy health care, social service, and welfare system.
- Tracking to insure that clients receive appropriate and quality prenatal care, are enrolled in support programs such as WIC, and are referred to higher levels of care when required, such as those services provided by the regional perinatal network.
- Follow-up to assure that clients are referred back to the primary care system after delivery.
- Continual assistance to assure clients are linked with needed social services, housing assistance, mental health and substance abuse counseling, and child care providers.
- Assistance in securing needed social services, housing assistance, mental health and substance abuse counseling, and child care.

A Strategic Plan recently developed by the Mayor's Advisory Committee and the Chicago Department of Health helps to cut through the complexity of the infant mortality problem and sets a sense of direction for the City's efforts. The Plan pulls together all the components of infant mortality in Chicago to help us understand the problem in depth and begin to define the interventions required if we are to have an impact on lowering our infant mortality and low birthweight rates. It should be noted that the complexity of the infant mortality problem has been cause for misunderstanding on the part of the general public and an attempt by some to reach for over-simplistic solutions.

The complexity of infant mortality lies in the integral relationship of the problem to the health and lifestyle of individuals intertwined with the socioeconomic environment of a community. For example, the influence of drugs, alcohol, and smoking is seldom considered significant yet the effects on maternal and child health can be profound. Likewise the withdrawal of funding from the social service support system of a community reaches down to the individual mother and infant. Thus, the problem must be considered from a comprehensive perspective; there is a synergy at work.

A special subcommittee on socioeconomic issues has been established to focus the attention of the full Mayor's Advisory Committee on ways in which organizations within city government and other public sector agencies can coordinate their efforts in making reduction of infant mortality a priority.

A second program designed to increase access to high quality inpatient obstetric care for the medically indigent is the Partnership in Health Program. Partnership in Health is a cooperative arrangement between selected Chicago-area community hospitals and the Chicago Department of Health. This program directly links a pregnant woman who receives prenatal care at a CDOH clinic with a specific, quality hospital, providing a prearranged minimum amount to the hospital as payment for the delivery. After delivery, the patient is referred back to the clinic for postnatal care and continuing primary care for her and her family. This program will help reduce the infant mortality rate by minimizing the number of women who receive no prenatal care, reducing the number of women using hospital emergency rooms for delivery, and by providing continuity of care throughout the pregnancy and infancy period.

A partnership has also been established with religious leaders across the city to enlist their support to raise the awareness of the community concerning infant mortality and the services that are available to members of their congregations.

Obstacles to Implementation

Several obstacles currently impede our efforts to fully implement a comprehensive range of solutions to the infant mortality problem.

First and foremost, insufficient resources hamper all efforts. There is simply not enough money to implement all the components of the IMRI model that are necessary to fight infant mortality.

While all levels of government need to reconsider their resource allocation decisions, more federal and state money is needed to fund medical care for the poor, to continue and expand the WIC program, and to expand the programs funded under the MCH Block Grant.

Greater coordination of the various enabling programs must begin at the Federal level to eliminate conflicting eligibility requirements and restrictive policies to allow more efficient use of the resources at hand.

Greater latitude at the state level to coordinate programs such as WIC and Food Stamps is needed to help prevent clients from falling through gaps in the system and allow greater use of allocated funds.

Cutbacks in other city programs have forced hard choices about who will receive care. With Community Development Block Grants and Revenue Sharing funds becoming scarce, cities are forced to choose between caring for one segment of the population at the expense of another.

An overall lack of understanding of the socioeconomic nature of infant mortality is another major obstacle. It is common belief that prenatal care alone will solve the infant mortality problem. Experience has shown that when an infant is sent home to an unhealthy environment, the benefits of good medical care can be swiftly undone.

Reduction of infant mortality must become a national priority on par with other issues of grave national concern. Policies must recognize that housing, employment and education are integrally related to infant mortality and are critical elements in the solution to the problem.

Chairman Miller. Thank you very much. Mr. Duffy.

STATEMENT OF EDWARD T. DUFFY, DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC AID, SPRINGFIELD, IL

Mr. Duffy. Thank you, Mr. Chairman and members of the Committee. For the record, my name is Edward Duffy, and I am the Director of the Department of Public Aid, and I would like to begin by thanking you all for being here today to talk about the problem in Illinois which I feel is very problematic, and seek your assistance in coming to some reasonable solutions.

This morning in Springfield, Dr. Bernard Turnock, Director of the Illinois Department of Public Health, testified before your committee on Illinois' efforts to combat our high rate of infant mortality. I would like to reemphasize that this State is committed to improve and expand our innovative programs to reduce such problems. Governor Thompson has assumed a national leadership role to address this problem. His efforts have been recognized on a national level by his appointment by you, the Members of Congress, to the National Commission to Prevent Infant Mortality, his chairing of the National Governors' Association, Task Force on Teen Pregnancy, and by the award of a $100,000 grant to our Parents Too Soon Program by the innovative Awards Program sponsored by the Ford Foundation and Harvard University's John F. Kennedy School of Government.

In 1985, Illinois' infant mortality rate was 11.6 deaths per 1,000 live births. This rate represented an all time low for Illinois, and capped a steady, twenty-year decline in our rate of infant deaths. While recognizing that this progress had been made, Governor Thompson knew that more needed to be done. This State increased its efforts to attain the Surgeon General's goal for 9 by 90, which is the support of 9 deaths per 1,000 live births by 1990. Funds totaling over $132 million have been appropriate over the 30-month period beginning January 1, 1986, for the reduction of infant mortality here in Illinois. The State's initiative, Families with a Future, is designed to ensure both quality care and continuity of care provided to individuals to stimulate both private and public agencies to work cooperatively to reduce infant mortality.

The Illinois Department of Public Aid has also been keenly aware of the problems of access to prenatal care of low income pregnant women and adequate care for their children in certain areas of Illinois. Access to medical care continues to be a major priority of this Department. The Department has found that one of the major factors inhibiting access to prenatal care is the high cost of medical malpractice insurance, which I will try to discuss later. The Department is focusing its efforts to address the total infant mortality care on preventative care.

One of our programs, Parents Too Soon, is one of the Nation's first coordinated statewide attempt to fight the problem of teen pregnancy. This innovative initiative, begun in 1983, is designed to reduce teen pregnancy, and to mitigate its negative consequences, health risks to mothers and infants, high rates of infant mortality, economic dependency, interrupted education, and premature parenting. Illinois has committed to spend $13.5 million during fiscal year 1988 for this program, which makes it one of the most generously supported programs of its kind in the country.

Parents Too Soon funds three comprehensive health social services and education demonstration projects, as well as 22 family planning programs, 26 prenatal programs, and 27 parent support programs. Two such programs are designed specifically to equip teenage mothers on welfare with job skills necessary to leave public dependency and establish self-sufficiency. Another of our preventive care programs is the Healthy Kids Program. The Health Kids Program is the name of the Department's federally mandated early and periodic screening, diagnosis and treatment program. The Healthy Kids Program provides periodic health examinations at given intervals as a means of preventive or early diagnosis and treatment of disease for all Medicaid eligible children under the age of 21 years. The program also provides dental care, immunizations, laboratory testing, such as hearing and vision screening.

The Department, through cooperation with the Department of Public Health, has two additional program components. A vaccine replacement program which permits the timely replacement of vaccines to physicians who administer immunizations, while substantially reducing the replacement cost of these vaccines through volume purchases by the Department of Public Health; and a blood lead survey program which permits epidemiological surveys of a child's living environment when the child is diagnosed as having a high level of blood lead.

The Healthy Kids Program is cooperating with Governor Thompson's Infant Mortality Reduction Initiative. The Department contracted with seven community based agencies in areas of high infant mortality to deliver outreach, follow-up, and case management services. These contractors supplement the efforts of local office staff in assisting clients to utilize the services. The total amount of the contracts is $800,000. A total of 6,200 families which include 10,000 children, were reached through this initiative.

In an outreach effort, the Department developed a Passport for Healthy Kids, which is given to all recipients with Medicaid eligible children under the age of 21. The passport is their record of medical treatment. A longer, more inclusive medical record booklet has been distributed to all medical providers serving Medicaid eligible children. An additional outreach effort is the poster of Healthy Kids, which is displayed in all local public aid offices.

Approximately 630,000 children are eligible for Healthy Kids services. During 1986, 201,271 initial and periodic health screenings were conducted. Of this total, 28,239 screenings, approximately 14.0 percent, resulted in the identification of one or more conditions in a child which needed further diagnosis or treatment.

Your Committee has requested that there be a discussion of access to prenatal care and delivery services for Medicaid eligible clients and the effect of the State's Medicaid reimbursement rates on the willingness of physicians to serve the public assistance clients. The Department knows that there is a shortage of available physicians, which appears to be growing, and that the major cause is the high rate of malpractice insurance for Illinois physicians. As a public agency, we have no control over the malpractice issue.

Our awareness of the access problem in downstate Illinois, however, has led us to devote staff time and effort to the following tasks: Meet with hospital and clinic administrators, physicians and other interested parties to explore vital alternatives. Serve on a task force appointed by Congressman Durbin to formulate an action plan for Central Illinois, where there has been a demonstrated lack of availability of prenatal care and delivery services for low-income women. Provide training seminars for billing staff of both in-state and out of state physicians who are willing to provide obstetrical care to Medicaid clients. In this regard, staff met with physicians in both the Paducah, KY, and Cape Girardeau, MO, and the areas surrounding to resolve billing issues through telephone contacts and correspondence.

Revising billing procedures on delivery services to align policy more closely to what happens with private pay maternity patients. This has resulted in an additional $5 million in reimbursement to providers of these services.

The Department is currently exploring options for providing financial incentives to obstetricians to ensure that they continue to provide services to Medicaid eligible women in Downstate Illinois and areas of high infant mortality within the State.

The Department is planning to implement—the implementation of expanded Medicaid coverage to pregnant women, as made available through the Federal Omnibus Budget Reconciliation Act of 1986, and as authorized by state law recently signed by Governor Thompson. Illinois Public Act 85-453, House Bill 295, enables the Department to provide Medicaid coverage for pregnant women whose income exceeds the Department's medically needy standard, but is below the Federal poverty level.

The Department will set the income standard for this new group of women between the current medically needy standard of $333 per month and the federal poverty level, depending on available funds to provide coverage for this new group of Medicaid eligible recipients.

Despite these efforts, however, there is and will continue to be an access problem for prenatal and delivery services in areas of this State because the most critical aspect of access to health care in areas experiencing shortages in medical providers is the increasing problem of escalating malpractice insurance rates. This problem is not intrinsic to providers serving Medicaid patients, but it is a problem for providers serving all patients.

We have received letters and comments from many providers explaining how they can no longer afford to provide prenatal and delivery services to our clients, or for that matter, to anyone, due to the escalating costs of doing business, especially doing business with malpractice insurance. Between the years 1976 and 1985, the average of costs of malpractice insurance for our physicians in Illinois rose an average of 22 percent per year, an increase of over 250 percent in that time period.

The Thompson administration has been working over the past three years to alleviate this problem through legislative means with limited success. The cost of doing business is driving physicians out of the high risk specialties, and this translates into fewer practitioners in rural and low-population centers.

The Department of Public Aid is a purchaser of medical services, not a provider. We have to seek providers for these services sorely needed by our clients, or by our patients. We have discovered that there are not enough providers who want to provide services to our clients, to our clients in downstate areas, even though they are outside the bounds of our providers—our clients.

Raising medical reimbursement is one answer. However, it is not the only answer for providing additional physicians to provide prenatal and delivery services for Medicaid patients.

I believe that if this Department raised its rates today, without some change in the malpractice situation, we would not draw the needed additional providers into the system, but merely increase the income of those physicians now providing services, mainly in the urban areas.

It has been testified, as I understand, before this Committee, earlier this morning, that even if we did increase those rates, most of that money would go to the attorneys who represent them on an annual basis.

To make it easier for the rural doctor to provide these services is by lowering the cost of doing business and access will improve.

I have discussed this problem with my counterparts in other states, who have stated to me that they are also experiencing similar problems. We are charged to work together to resolve these problems. And to do so with Congress to create new and innovative programs to ensure that both Medicaid eligible as well as non-Medicaid eligible pregnant women and children, particularly those in rural areas, can access needed health services.

I again thank you for the opportunity of testifying before this Committee, and would be happy to respond to any questions the Committee might have.

[Prepared statement of Edward T. Duffy follows:]

PREPARED STATEMENT OF EDWARD T. DUFFY, DIRECTOR, ILLINOIS DEPARTMENT OF PUBLIC AID, SPRINGFIELD, IL

Good afternoon, I am Ed Duffy, Director of the Illinois Department of Public Aid. The Department administers the Medicaid Program in Illinois. Thank you for the opportunity to discuss the problem of Infant Mortality in this State today.

This morning in Springfield, Dr. Bernard Turnock, Director of the Illinois Department of Public Health, testified before your committee on Illinois' efforts to combat our high rate of infant mortality. I would like to reemphasize that this State is committed to improve and expand our innovative programs to reduce infant deaths. Governor Thompson has assumed a national leadership role to address this problem. His efforts have been recognized on a national level by his appointment by Congress to the National Commission to Prevent Infant Mortality, his chairing of the National Governors' Association Task Force on Teen Pregnancy, and by the award of $100,000 to our "Parents Too Soon" program by the Innovations Awards Program sponsored by the Ford Foundation and Harvard University's John F. Kennedy School of Government.

In 1985, Illinois' infant mortality rate was 11.6 deaths per 1,000 live births. This rate represented an all-time low for Illinois, and capped a steady, 20-year decline in our rate of infant deaths. While recognizing that progress had been made, Governor Thompson knew more needed to be done. This State increased its efforts to attain the Surgeon General's goal for the country of 9 deaths per 1,000 live births by 1990. Funds totaling over $132 million have been appropriated over the 30-month period beginning January 1, 1986 for the reduction of infant mortality in Illinois. The State's initiative, "Families With A Future", is designed to ensure both quality care and continuity of care is provided to individuals to stimulate both private and public agencies to work cooperatively to reduce infant mortality.

The Illinois Department of Public Aid has also been keenly aware of the problems of access to pre-natal care of low income pregnant women and adequate care for their children in certain areas of Illinois. Access to medical care continues to be a major priority of the Department of Public Aid. The Department has found that one of the major factors inhibiting access to prenatal care is the cost of medical malpractice insurance which I will discuss later. The Department is focusing its efforts to address the total infant mortality problem on preventative care.

One of our programs, Parents Too Soon, is the nation's first coordinated statewide attempt to fight the problem of teen pregnancy. This innovative initiative, begun in 1983, is designed to reduce teen pregnancy and to mitigate its negative consequences: health risks to mothers and infants, height rates of infant mortality, economic dependency, interrupted education and premature parenting. Illinois has committed to spend $13.5 million during fiscal year 1988 for this program, which makes it one of the most generously supported state programs of its kind in the country.

Parents Too Soon funds three comprehensive health, social services and education demonstration projects, as well as 22 family planning programs, 26 prenatal programs and 27 parent-support programs. Two such programs are designed specifically to equip teenage mothers on welfare with jobs skills necessary to leave public dependency and establish self-sufficiency.

Another of our preventative care programs is the Healthy Kids Program. The Healthy Kids Program is the name of the Department's federally mandated Early and Periodic Screening, Diagnosis and Treatment Program. The Healthy Kids Program provides periodic health examinations at given intervals as a means of prevention or early diagnosis and treatment of disease for all Medicaid eligible children under the age of 21 years. The program also provides dental care, immunizations, laboratory testing, as hearing and vision screening.

The Department, through cooperation with the Department of Public Health, has two additional program components:

. a vaccine replacement program which permits the timely replacement of vaccines to physicians who administer immunizations, while substantially reducing the replacement cost of the vaccines through volume purchases by the Department of Public Health; and

. a blood lead survey program which permits epidemiological surveys of a child's living enviornment when the child is diagnosed as having a high level of blood lead.

The Healthy Kids Program is cooperating with Governor Thompson's Infant Mortality Reduction Initiative. The Department contracted with seven community-based agencies in areas of high infant mortality to deliver outreach, follow-up and case management services. These contractors supplement the efforts of local office staff in assisting clients to utilize the services. The total amount of the contracts is $800,000. A total of 6,200 families which included 10,000 children were reached through this initiative.

In an outreach effort, the Department developed a "Passport for Healthy Kids" which is given to all recipients with Medicaid-eligible children under age 21. The "Passport" is their record of medical treatment. A longer, more inclusive medical record booklet has been distributed to all medical providers serving Medicaid-eligible children. An additional outreach effort is the poster of "Healthy Kids" which is displayed in all local Public Aid Offices.

Approximately 630,000 children are eligible for Healthy Kids services. During 1986, 201,271 initial and periodic health screenings were conducted. Of this total, 28,239 screenings (14.0 percent) resulted in the identification of one or more conditions in a child which needed further diagnosis or treatment.

Your committee has requested that there be a discussion of access to prenatal care and delivery services for Medicaid eligible clients and the effect of the State's Medicaid reimbursement rates on the willingness of physicians to serve public assistance clients. The Department knows that there is a shortage of available physicians which appears to be growing, and that the major cause is the high rate of malpractice insurance for Illinois physicians. As a public agency we have no control over the malpractice issue.

Our awareness of the access problem in downstate Illinois; however, has led us to devote staff time and effort to the following tasks:

* Meet with hospital and clinic administrators, physicians and other interested parties to explore alternatives.

- Serve on a task force appointed by Congressman Durbin to formulate an action plan for central Illinois where there has been a demonstrated lack of availability of prenatal care and delivery services for low income women.

- Provide training seminars for billing staff of both in-state and out-of-state physicians who are willing to provide obstetrical care to Medicaid clients. In this regard, staff met with physicians in both the Paducah, Kentucky and Cape Girardeau, Missouri areas and continue to resolve billing issues through telephone contacts and correspondence.

- Revising billing procedures on delivery services to align policy more closely to what happens with private pay maternity patients. This has resulted in an additional $5 million in reimbursement to providers of these services.

- The Department is currently exploring options for providing financial incentives to obstetricians to ensure that they continue to provide services to Medicaid eligible women in downstate Illinois and areas of high infant mortality within the State.

- The Department is planning implementation of expanded Medicaid coverage to pregnant women, as made available through the Federal Omnibus Budget Reconciliation Act of 1986 and as authorized by state law recently signed by Governor Thompson. Illinois Public Act 85-453 (House Bill 295) enables the Department to provide Medicaid coverage for pregnant women whose income exceeds the Department's medically needy standard, but is below the federal poverty level.

> The Department will set the income standard for this new group of women between the current medically needy standard of $333 per month and the federal poverty level, depending on available funding to provide coverage for this new group of Medicaid eligible recipients.

Despite these efforts; however, there is and will continue to be an access problem for prenatal and delivery services in areas of this State because the most critical aspect of access to health care in areas experiencing shortages in medical providers is the increasing problem of escalating malpractice insurance rates. This problem is not intrinsic to providers serving Medicaid patients - it is a problem for providers serving all patients.

We have received letters and comments from many providers explaining how they can no longer afford to provide prenatal and delivery services to our clients or to anyone due to the escalating costs of doing business, especially malpractice insurance. (Note: Statistical information on the cost of malpractice insurance will be inserted here.) The Thompson administration has been working over the past three years to alleviate this problem through legislative means with limited success. The cost of doing business is driving physicians out of high risk specialties and this translates into fewer practitioners in rural and low population centers.

The Department of Public Aid is a purchaser of medical services not a provider. We have to seek providers for the services sorely needed by our clients. What we have discovered is there are not enough providers who want to provide services to our clients or to any clients in downstate areas of Illinois.

Raising medical reimbursement is not the only answer for finding additional physicians to provide prenatal and delivery services to Medicaid clients. I believe if this Department raises its rates without some change in the medical malpractice situation, we would not draw any additional providers but merely increase the incomes of those physicians now providing such services in our mainly urban areas. Make it easier for the rural doctor to provide services by lowering the cost of doing business, and access will improve.

I have discussed this problem with my counterparts in other states, who have stated to me that they are also experiencing these same problems. We are charged to work together to resolve these problems and to work with the Congress to create new and innovative programs to ensure that both Medicaid eligible and non-Medicaid eligible pregnant women and children, particularly in rural areas, can access needed health services.

I would be happy to respond to questions of the committee and thank you again for the opportunity to testify today.

Chairman MILLER. Thank you. Mr. Stermer?

STATEMENT OF JEROME STERMER, PRESIDENT, VOICES FOR ILLINOIS CHILDREN, CHICAGO, IL

Mr. STERMER. Thank you, Congressman Miller and members of the Committee. My name is Jerome Stermer, and I am President of Voices for Children. Ours is a new, not-for-profit organization dedicated to the helping of children and youth in Illinois. Our Board of Directors includes representatives of a wide cross-section of business, professional, civic, and community leaders in our State.

Here in Illinois, we suffer from one of the worst infant mortality rates in the Country, with the situation being worse in Chicago than in the rest of the state. The overall rate, as has been discussed here, is 12 deaths per 1,000 live births, with the minority death rate in Chicago reaching 21 deaths per 1,000. If we compare this reality with the goal of the Surgeon General, we come to the sobering realization that over 500 babies in our State die unnecessarily each year.

In this group, Black babies and Hispanic babies are tragically over-represented. This death rate is the greatest consequence of inadequate prenatal care, but there are other costs. The alarming rate of low birthweight babies, 15 percent of births among minorities in Chicago, also increases the risks of childhood disability and failure in school.

These shocking figures represent unnecessary tragedy. They are even more shocking in light of the opportunity that Congress has given us in Illinois to do something about the problem.

The rest of my statement this afternoon will be specific to the SOBRA legislation adopted in October of last year by Congress, which affords each state the opportunity to decouple Medicaid coverage for uninsured pregnant women from the cash assistance program of AFDC.

The Congress established the beginning date of this program as April, 1987. In Illinois, we have not yet begun the program, and as Director Duffy testified, we are now only in the planning stages, not looking to implement before July of 1988.

Our failure to implement the SOBRA action prior to July of 1988 violates our common ethical traditions. Beyond that, it fails the test of economic common sense. The number of independent calculations show that insuring our uninsured pregnant women will more than pay for itself during the first 12 months. The money would be saved by a reduction in the number of babies who need expensive neonatal intensive care. The up-front costs to Illinois of insuring these women under the SOBRA legislation is about $2 million per year. The net cost is nothing. Some states implementing SOBRA have calculated a net savings. They are estimating that for every new dollar spent on new prenatal care, $3 will be saved during the child's first year of life.

So babies are dying in Illinois, for a dime's worth of attention. Let me give you some figures and indicate that a more complete text of our organization's analysis is given to staff for entry in the record.

Each year, we estimate that more than 11,000 women in Illinois give birth without the SOBRA Medicaid coverage. That is, they are working women, uninsured, but eligible for the new Medicaid coverage. Others are women who are supported by their husbands, who have jobs, but not family coverage. Imagine for moment an uninsured, single woman who works 40 hours a week at a fast-food place just to maintain the meager income necessary to keep off of welfare. For this person, the cost of adequate prenatal care is entirely prohibitive.

These women are ineligible for Medicaid, because their incomes are too high. They are eligible for the medically needy program, only after they have met their monthly medical expense spend-down amount. Spend-down as you know, is a system designed to discourage women from taking this action. For some, the only chance to protect their babies would be to quit employment and requalify for Welfare.

So, the State's current response to women without prenatal care, for whom prenatal care could mean the difference between life and death, health and disability for their babies, is our bureaucratic procedure calculated to discourage the most concerned and persistent mother. These mothers are pleading for healthy babies, and we are giving them monthly application forms.

All over the State of Illinois, women, many of whom are children themselves, arrive at hospital emergency rooms to deliver babies, having had no prenatal care. Somehow, we are willing to spend an unlimited amount on treatment for a baby with life-threatening problems, but we cannot bring ourselves to spend the $450 to prevent those problems. Congress should be angry that we are spending large amounts of Medicaid dollars to treat avoidable handicaps, and not spending the fraction of those dollars it would take to avoid them. It should consider that we regularly spend $30,000 or more per child for neonatal intensive care, and/or the sky-high cost of the lifetime of special education, welfare, or institutional residence for children who, in many cases, could have been born healthy.

We, in Illinois, should be ashamed that we are permitting the needless death of newborn babies. Babies are dying for no other reason than inertia.

We seek your help and the help of everyone here today to remedy this tragedy. We must persuade the Illinois Department of Public Aid to immediately begin providing medical assistance coverage for prenatal care to all women whose family incomes fall below the federal poverty level. We believe this would be a major step toward reducing our inexcusably high rate of infant mortality and avoidable birth defects.

Thank you.

[Prepared statement of Jerome Stermer follows:]

PREPARED STATEMENT OF JEROME STERMER, PRESIDENT, VOICES FOR ILLINOIS CHILDREN, CHICAGO IL

Medical Coverage for Uninsured Pregnant Women in Illinois

My name is Jerome Stermer. I am the President of Voices for Illinois Children. Voices is a new not-for-profit organization dedicated to improving the well-being of children and youth in Illinois. The Voices board of directors includes representatives of a wide cross section of business, professional, civic and community leaders in Illinois.

In our state we suffer from one of the worst infant mortality rates in the country, with the situation being worse in Chicago than in the rest of the state. The overall infant mortality rate in Illinois is 12 deaths per thousand live births, with the minority death rate in Chicago reaching 21 deaths per thousand. If we compare this reality with the goals of the Surgeon General, we come to the sobering realization that over 500 babies die unnecessarily each year in Illinois. In this group, black babies and Hispanic babies are tragically overrepresented. This death rate is the grimmest consequence of inadequate prenatal care, but there are other costs. The alarming number of low birth weight babies, 15 percent of births among minorities in Chicago, also increases the risk of childhood disability.

These shocking figures represent unnecessary tragedy. And they are even more shocking in light of the opportunity the United States Congress has given us to do something about the problem. We welcomed the SOBRA legislation which would provide half the cost of medical benefits for uninsured pregnant women in Illinois, in families at or below the Federal poverty level.

But, sadly, we have to report that our decision makers have failed to take advantage of this opportunity to save lives. SB833 was recently signed into law. This requires our state Medicaid agency, the Department of Public Aid, to design a plan to implement SOBRA, but there is no deadline for implementation and no guarantee how many mothers will be insured.

Our failure to take this life-saving action violates our common ethical traditions. Beyond that, it fails the test of economic common sense. A number of independent calculations show that insuring our uninsured pregnant women will more than pay for itself during the first twelve months. The money would be saved by a reduction in the number of babies who need expensive neonatal intensive care. The up-front cost to Illinois of insuring these women and their babies under the SOBRA legislation is about $2 million dollars per year. The net cost is nothing. Some states have calculated a net savings to the state. They are estimating that for every new dollar spent on prenatal care, three dollars will be saved in the child's first year of life.

So babies are dying in Illinois for a dime's worth of attention.

Let me give you some more figures. Each year, more than 11,000 eligible women in Illinois deliver babies without SOBRA Medicaid coverage. Some are working women who have low paying jobs that do not offer health coverage. Others are women who are supported by husbands who have jobs but no family coverage. Imagine for a moment the uninsured single mother who works 40 hours a week at a fast-food place just to maintain a meager income and keep off welfare. For her, the cost of adequate prenatal care is entirely prohibitive.

These women are ineligible for Medicaid because their incomes are too high. They are eligible for Medical Assistance No-Grant (MANG) only after they have met their monthly medical expense spend-down amount. The spend-down is custom designed to discourage women from taking this option. For some, the only chance to protect their babies would be to quit employment and re-qualify for welfare.

So the state's current response to women without prenatal care, for whom prenatal care could mean the difference between life and death, health and disability for their babies, is a bureaucratic procedure calculated to discourage the most concerned and persistent mother. These mothers are pleading for healthy babies and we are giving them monthly application forms. All over the State of Illinois women-- many of whom are children themselves-- arrive at hospital emergency rooms to deliver babies, having had no prenatal care. Somehow, we are willing to spend an unlimited amount of money on treatment for a baby with life-threatening problems, but we can't bring ourselves to spend $450 to prevent those problems.

Congress should be angry that we are spending large amounts of Medicaid dollars to treat avoidable handicaps, and not spending the fractions of those amounts that it would take to avoid them. It should consider the average $30,000 per child that is required for neonatal intensive care, or the sky-high cost of a lifetime of special education, welfare or institutional residence for children who, in many cases, could have been born healthy.

And we in Illinois should be ashamed that we are permitting the needless deaths of newborn babies. Babies are dying for no reason other than inertia. We seek your help, and the help of everyone here today, to remedy this tragedy.

We must persuade the Illinois Department of Public Aid to immediately begin providing medical assistance for prenatal care to all women whose family incomes fall below the federal poverty level. We believe this would be a major step toward reducing our inexcusably high rate of infant mortality and avoidable birth defects.

VOICES FOR ILLINOIS CHILDREN

MEDICAL COVERAGE FOR UNINSURED PREGNANT WOMEN
A COST-EFFECTIVE STRATEGY

Summary

Each year more than 11,000 low-income women in Illinois cannot afford prenatal care during their pregnancies. This group of women is also ineligible for AFDC. They have a significantly higher risk of delivering low birth weight babies, who in turn have a much higher risk of not surviving infancy or of developing chronic handicaps.

A new federal extension of Medicaid would allow Illinois to provide prenatal, delivery, and postnatal care to these women and their children at a cost to the state of only $2 million. The state budget will experience a net cost saving from the program in the first year. The cost savings come from the reduced need for intensive neonatal care and care for chronic disabilities.

Twenty-six states have already signed up for this program.

Voices for Illinois Children urges the Governor and the Department of Public Aid to enroll the state in this program immediately to save lives, improve the health of Illinois children, and save dollars.

Voices Report 87-1/2

EXTENDING MEDICAID COVERAGE FOR UNINSURED PREGNANT WOMEN, THEIR INFANTS AND YOUNG CHILDREN: A COST-EFFECTIVE STRATEGY

BACKGROUND

Each year, approximately 11,400 low-income women, who do not qualify for AFDC, cannot afford to pay for prenatal care. These are working women who have low-paying jobs that do not offer insurance benefits, or who are supported by husbands without family health coverage. In either case the family income is below the federal poverty line.

Studies have shown that inadequate prenatal care often leads to medical complications during pregnancy and childbirth that can result in low birth weight, infant death, and a lifetime of unnecessary handicaps. Low birth weight infants often require very expensive neonatal care and sometimes long-term institutional and medical care.

UNINSURED PREGNANT WOMEN AND MEDICAID

These women are ineligible for AFDC because their income is too high. They are eligible for Medical Assistance No-Grant (MANG) ONLY after they have met the monthly "spend-down." Monthly "spend-down" is the amount by which monthly income exceeds the AFDC eligibility level for cash assistance. Under the current system, a woman receives no state medical assistance unless the cost of the care exceeds her spend-down level. The spend-down amount has to be recalculated every month in a complicated procedure. Both the spend-down requirement and the monthly recalculation process discourage women from getting the inexpensive prenatal care that can mean the difference between a healthy baby and a sick baby.

FEDERAL MATCHING FUNDS FOR MEDICAID EXTENSION

The 1986 Sixth Omnibus Budget Reconciliation Act (SOBRA) established an unprecedented opportunity to use federal money to pay half of the state's cost of prenatal and pregnancy-related care for poor women and their infants.

Voices for Illinois Children estimates that the new yearly cost to the state of providing medical benefits to this group of uninsured pregnant women would be $2.1 million. This is in contrast to the Department of Public Aid's figure of $22 million.

Voices has called upon the Department of Public Aid to enroll the state in this program immediately for all uninsured women whose family incomes are at or below the poverty line.

SB 333, approved by the Illinois General Assembly this Spring and recently signed by the Governor, authorizes the Department of Public Aid to plan for the provision of prenatal and early infant care to women whose incomes are under the federal poverty level but in excess of the state's AFDC and Regular MANG (no spend-down) eligibility levels.

While this legislation is a first step in the extension of Medicaid to uninsured women, it does not contain an implementation date, and does not specify eligibility standards within the federal guidelines. In consequence, Voices for Illinois Children and many other organizations and coalitions have requested the Governor to instruct the Department of Public Aid to enroll the state in this program as soon as possible, for ALL uninsured pregnant women whose family incomes are at or below the poverty line. Presently, twenty-six states have passed legislation to implement this program, and most of them have extended eligibility up to 100% of the poverty level.

ESTIMATED COSTS

PRENATAL CARE, DELIVERY, AND POSTNATAL CARE

Under the current Medicaid system the state pays most of the delivery cost for women eligible under SOBRA. Once the new system is adopted, the only new cost to the state for these women will be the amount they now incur as their monthly spend-down obligation.

The average difference between the Medicaid eligibility level and the federal 100% poverty level for families of six or fewer is approximately $416. The National Governors Association (NGA) report (March, 1987) indicates that poor, uninsured women's incomes are fairly evenly distributed between the Medicaid and the poverty income levels. It can be reasonably assumed, therefore, that the average monthly spend-down is half of this, or $208. Multiplying this amount by the 11,400 women who would be eligible under SOBRA gives an approximate cost figure of $2.4 million. This would be borne equally by the state and federal governments, so the cost to Illinois taxpayers would be about $1.2 million.

INFANT AND YOUNG CHILD CARE

Under MANG, the state pays the expenses for infants who need intensive care. Under SOBRA, the additional cost to the state per sick baby would be the average spend-down liability of $208. In addition, healthy babies would enjoy the same medical benefits provided to children under Medicaid. These include the Healthy Kids program, physicians' visits, and laboratory services.

The total additional cost of providing well-baby care and sick-baby care is approximately $1.8 million, of which the state will pay half, or about $0.9 million, for infants and children under age two. This brings the total state cost of this Medicaid extension to $2.1 million.

THE EFFECTIVENESS OF PRENATAL CARE AND COST SAVINGS

Prenatal care can identify problems leading to prematurity and low birth weight among infants. Studies have demonstrated that access to adequate prenatal care can reduce the risk of low birth weight and infant death, and is critically important to ensuring a healthy birth.

A national study estimates that every dollar spent in prenatal care saves about $3.38 in hospital care for low birth weight infants in the first year; a Colorado study estimates $11.00 in additional savings during the life of the child. The same study conducted by the Institute of Medicine in Washington, D.C. estimates that the extension of prenatal care to the SOBRA population would reduce the number of low birth weight births to mothers in this group from 11.5% to 9% of all births.

A California study shows that low birth weight rates for women receiving comprehensive Medicaid maternity coverage were 50% less than among those not participating in the program. The study estimated that every Medicaid dollar spent on expanded prenatal and obstetric programs would result in a savings of $4 from reduced need for neonatal intensive care and rehospitalization in the first year of life.

Michigan estimates that the state can save 25% of expensive neonatal care if Medicaid-eligible women receive early and adequate prenatal care.

THE MOST CONSERVATIVE OF THESE COST ESTIMATES WOULD GIVE ILLINOIS A NET COST SAVING IN THE FIRST PROGRAM YEAR.

CONCLUSION

Prenatal care reduces infant mortality, low birth weight babies, and postnatal medical complications. Prenatal care is also a strategy that reduces costs at the same time that it improves the health of mothers and children. The sooner Illinois takes advantage of this federal opportunity, the sooner the health of Illinois infants will improve and the greater the cost savings to the Illinois taxpayer.

APPENDIX I

Estimated costs of extended Medicaid coverage for uninsured pregnant women, their infants and young children.

A. PREGNANT WOMEN

Estimating:

1)	Number of potentially eligible women for family sizes of 2, 3, 4, 5, and 6.	11,416
2)	Cost for prenatal care, delivery, post-natal care for both mother and infant	2,532
3)	Total costs for prenatal care, delivery, and post-natal care for 11,416 women and their infants	$28,905,312

B. CHILDREN UNDER AGE TWO

Estimating:

1)	Total number of infants & children under age two Newborns: 11,416 Children under age two: 11,416	22,832*
2)	Total Medical costs for infants and children under age two	$4,758,786
	Healthy children: 11,873 x $72 (includes Healthy Kids program, physicians' visits, and labs per child per year)	$854,856
	Sick children: 4,566 x $855 (includes physicians' visits, labs, and hospitalizations)	$3,903,930
	Total number of children served	16,439
	Total number of children not served	6,393
	Total	22,832

* National studies estimate that 80% of these children would not continue their medical coverage after their first month of eligibility. This indicates that these children would remain relatively healthy and would not incur large medical costs. However, the NGA report estimates that only 65% of these healthy children would participate in this Medicaid coverage. The remaining 20% of the children are more likely to be sick and would incur large medical expenses.

C. UNADJUSTED TOTAL COSTS FOR SOBRA

For newly eligible women	$28,905,312
For infants and children under age two	$4,758,786
Total costs for SOBRA	$33,664,098
State's unadjusted total cost	$16,832,049
DPA's estimate of unadjusted total cost of SOBRA* **for 13,000 newly eligible women and** **26,000 infants and children under age 2**	$43,212,000
DPA's estimate of unadjusted cost for the state	$21,606,000

D. ESTIMATED SOBRA COSTS ADJUSTING FOR SPEND DOWN

1)	Costs for 11,416 newly eligible women 11,416 x $208	$2,374,528
2)	Total costs for children under age two	$1,804,584
	Healthy children: 11,873 x $72	$854,856
	Sick children: 4,566 x $208	$949,728
3)	Total costs for SOBRA	$4,179,112
	State's total full year cost	$2,089,556

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* DPA's estimated cost for SOBRA is much higher than Voices' estimate, for two main reasons. First, DPA's figure of 13,000 newly eligible women (from the NGA report) is inflated because it includes women whose incomes could qualify them for AFDC or Regular MANG programs in which DPA fully covers their Medicaid. Second, DPA's estimated costs are not adjusted for the spend-down. This would be the new cost to the state, since under the current system the state pays most of the delivery cost for women eligible under SOBRA.

Sources of Voices' Estimates:

1) Number of newly eligible women (11,416) is based on the National Governors Association report (NGA, March 1987) calculating the income distribution of women between 15 and 44 years old below the federal poverty level but above the medically indigent standards for the Midwest region.

2) Number of infants (11,416) is estimated by Voices from the NGA report. Number of children under age two is twice the number of infants estimated by Voices.

3) Pregnancy-related costs, including physicians' charges, are obtained from the Illinois Department of Public Health by phone. Delivery cost for both mother and infant is obtained from Illinois Health Care Cost Containment Council, Report 3, fourth quarter of 1985.

4) Costs for healthy children are obtained from DPA's A Report to the Illinois General Assembly on the Early and Periodic Screening, Diagnosis and Treatment Program submitted by Gregory L. Coler on November 1, 1986 (adjusted for 1987 inflation).

5) State's Medical Assistance No-Grant standard is obtained from Statistical Publication from the Research Division of Illinois Department of Public Aid (E-6, rev. 11-86).

6) Federal poverty level is obtained from the U.S. Department of Health and Human Services by phone.

7) National cost saving estimate is obtained from the Committee to Study the Prevention of Low Birthweight, "Preventing Low Birthweight." Washington, D.C.: Institute of Medicine, 1985.

8) Colorado's cost saving estimate is obtained from Bondy, Jessica, "Cost Benefit of Prenatal Care" (Colorado Task Force on the Medically Indigent, Boulder, CO, 1983).

9) California's cost saving estimate is obtained from the State of California, Department of Health Services, "Preliminary Evaluation of the Obstetrical Access Pilot Project (July, 1979-June, 1980)" (December, 1982).

APPENDIX II

STATES WHICH HAVE PASSED SIMILAR LEGISLATION

Twenty-six states have passed legislation to implement optional Medicaid coverage for uninsured pregnant women and their children. Most of them have extended eligibility up to 100% of the poverty level.

- Arizona
- Arkansas
- Connecticut
- Delaware
- District of Columbia
- Florida
- Kentucky
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- New Jersey
- New Mexico
- North Carolina
- Ohio
- Oklahoma
- Oregon
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Vermont
- Washington
- West Virginia

Source: Children's Defense Fund

Chairman Miller. Thank you. Ms. Artis?

STATEMENT OF JENNIFER ARTIS, PRESIDENT, HEALTHY MOTHERS AND HEALTHY BABIES COALITION; EXECUTIVE DIRECTOR, ST. BASIL'S FREE PEOPLE'S CLINIC, CHICAGO, IL

Ms. Artis. Hi. I was asked to come and present testimony regarding the access of care to prenatals. This is very difficult for me at this time, as I hear a lot about programs, and I hear a lot about money, and that is all well and good. People like to do those kinds of things. But as the Executive Director of St. Basil's Free People's Clinic (our clinic is totally free, and it is all volunteer) in the last 6 years on the southwest side of Chicago, I saw the biggest problem of access being fear. The fear that they were not being made to feel like a woman. That they are not appreciated as a person. If you want to look at problems, the number one problem is that we forget that we are dealing with people. We are dealing with women who have come from socioeconomic backgrounds that make it very difficult to access any system.

They are afraid of systems. And I am not afraid to say that many times they think that Public Aid is a Gestapo. That many times they walk into an office, and that office turns them off and turns them cold, and they would rather go back home and wait for the last minute—a crisis to occur.

We are dealing with people. What has ever happened to the compassion of the agencies that are represented here today? To go into an agency where I am no longer a person, being responded to not as an individual, but as a number, as a problem, as a target audience, and these dead babies. But that dead baby could have become a human being. Something that is qualitative, something that is creative. Health has to go to the community. The person cannot go to the health agencies any more, because the health agencies have locked them out. They do not trust them, and you cannot blame them.

As Mrs. Scott said, how many of us in this room have been in that situation, where our bodies are put on the block, and we are asked to expose ourselves, before people we do not know. That takes something away from being a woman. If you cannot care for yourself, how can you care for a life that you are carrying?

We have to go back to basics. We have to have support programs in the community that says "you are important." We have to have education programs that teach Moms, and teach the community, how to take care of itself. The money should be given to projects that encourage people to do it on their own. Not to programs that encourage dependency. Because we are not doing a very good job of taking care of other people. We have failed, miserably.

I, too, often get caught up in the position as president of Healthy Mothers, Healthy Babies, I go downtown and I am in an office, and I am making money. And I get aggravated about the crisis problems I forget the people until I go to the clinic in the evenings, and then I am meeting with the people who are suffering. And I then look at myself, and say, you forgot, Jennifer. You are dealing with people. You have to love them, you have to care for them. You have to care about babies to give them life.

On the West side of Chicago, where there is a very viable hospital setting, and yet it is the highest infant mortality area in the city of Chicago. Why? What is the problem? Some will say transportation. We can always find a problem to get where we do not want to go, if there is something there that we do not want to deal with. But if the system opened up its arms and said, we want to truly take care of you, because you are a person, you are viable, you are ready. Then I think the response would be different.

I cannot speak on these other issues, simply because you know them. You have heard them before and how many testimonies have we gone into? I can yell from the top of this building, and it will still not make any difference, unless you start changing the structure that services women. That says you are a human being, and of value. That your body is sacred, and your baby is sacred.

And that is all I have got to say, folks.

[Prepared statement of Jennifer Artis follows:]

Prepared Statement of Jennifer Artis, President, Health Mothers and Healthy Babies Coalition and Executive Director of the St. Basil's Health Service-Free People's Clinic, Chicago, IL

It is an honor to be here today to relate the concerns of caring Chicagoans regarding maternal and child health care problems. I am Jennifer Artis, President of the Healthy Mothers and Babies Coalition and Executive Director of the St. Basil's Health Service-Free People's Clinic.

The St. Basil's Health Service-Free People's Clinic is located in the New City community on the Southwest side of Chicago. We service four community areas: Englewood, West Englewood, New City, and Back of the Yards. We are an all volunteer community clinic staffed by physicians, dentists, pharmacists, community people, nurses, and people of good will. Our Clinic was established in 1982 in response to the cutbacks in Medicaid and Medicare which caused an acute problem of access to quality medical care.

Since opening our doors we have seen over 8,000 new patients and have over 12,000 patient visits annually. We service Hispanics, Blacks, and Whites at every age level. We provide primary medical care, laboratory, dentistry, pharmaceuticals, acupuncture, and social service referrals and coordination of tertiary specialists.

In my capacity as chief cook and bottle washer of the St. Basil's Clinic, I have had the opportunity to work with the patients at every level, from entry to exit. I have observed that the chief problem of accessing the medical system for adequate and quality care is financial: affected are those lacking third party medical insurance, the newly unemployed on unemployment compensation, the Medicaid-restricted recipients and the Medicare elderly who must wrestle with spenddowns.

I have personally had hospitals call and request that we follow-up on patients for whom they can no longer care because of changing institutional policies regarding acceptance of the indigent as patients. I have witnessed a hospital's refusal to provide service to a rape victim because she was on Medicaid. I have seen the elderly unable to meet their spenddowns; they come to us broken and depressed because their long years of labor are no longer honored. I have worked with a kidney transplant vicitm who was being discharged because her insurance ran out. I have witnessed children in need of dental, optometric, and psychological care left in the breech of a society that offers screening but no practical services. These children are left out because of their poverty, unless their parents choose a life style of complete denial of basics to provide these services. I have worked with a mother whose son had a brain tumor and had his life weighed on a scale of "how much and when can you pay for his surgery?" I have seen too many women with cancer go untreated until a medical institution had no choice but to take them in. I have seen all of this and worked with it for the past five years. These are the stories of our third world -- the world of the medically disadvantaged.

As President of the Healthy Mothers and Babies Coalition, I am working with a dedicated group of people whose mission is to use research, education, and advocacy to assure that current programs and policies in maternal and child health care actually provide effective service to those in greatest need. The Coalition, founded in 1983, attacks the social, economic, and political conditions that contribute to Chicago's acute access to care and infant mortality problems. As an advocacy organization, the Coalition analyzes and searches for answers to both the readily-apparent causes of infant mortality, and the underlying problems of access to care. These underlying problems range from inadequate day care to transportation problems, from lack of quality education and lack of information about available prenatal services to fear of intricate institutional procedures for receiving social services. Other factors include housing and homelessness, mental illness, and hereditary predispositions.

In recent days, there has been considerable controversy regarding the City of Chicago's infant mortality rate. It is unfortunate that the controversy surrounding the relative accuracy of the infant mortality data developed by various government agencies has overshadowed a number of fundamental truths about the desperate fight for life now being waged by many Chicago-area children.

It is true that in some Chicago communities, one in every 34 babies dies before its first birthday. It is true that babies in Chicago's non-white communities die at a rate more than double that of their white counterparts. It is true that pregnant women without private medical insurance often wait three months or more for their first clinic pre-natal medical examination (and thus cannot follow the standard medical advice to seek medical care during the critical first trimester of pregnancy). It is true that Chicago is experiencing an epidemic of children having children. It is true that teen pregnancy is a leading cause of high school dropouts. It is true that Chicago is a dangerous place to be born.

These realities are all the more tragic because they are preventable. Infant mortality CAN be reduced. Research has proven that infant health CAN be improved, with timely prenatal care, good nutrition, and abstinence from smoking, alcohol and drugs during pregnancy. Better housing, education, and employment opportunities are also critical.

Clearly, the root cause of infant mortality in Chicago is multi-dimensional. To effectively attack this problem, all levels of government must make a strong commitment to the development of comprehensive social programs that serve those in greatest need.

CITY OF CHICAGO

In Chicago, there are a number of steps that must be taken to effect a change in the infant mortality rate. At the city level, perhaps the single most important objective should be the appointment of a dedicated, caring professional who is familiar with maternal and child health issues to the post of Commissioner of the Department of Health. With such a person at the helm, the Department of Health could make the following health care improvements:

1. Contribute to the level of funding and improve the efficiency of the WIC supplemental food program, a program believed by most authorities to be an effective tool in reducing low birthweight babies.

2. Expand home health care services (public health nurses, nutritionists, outreach workers) to better cover the 19 high-risk communities, as well as the remainder of the city.

3. Seek licensure as a licensed home health care agency, which would allow the city to seek state reimbursement for certain types of care.

4. Initiate a thorough, comprehensive, and independent evaluation of the IMRI networks to determine if the program initiated in the early 1980's is being effectively and efficiently administered.

5. Follow recent recommendations by noted local health professionals (including Dr. Quentin Young and Dr. Jorge Prieto and others) to develop an effective program for community access to health care. This will require the initiation of a cooperative plan with the county and state to address the problems of Cook County, Provident, University of Illinois and other hospitals facing fiscal crises and care cutbacks for the needy.

6. Develop and promote in-school nutrition, health, child care, and pregnancy prevention programs to provide young people with the information they need to prevent unplanned pregnancy and to better equip young men and women for the responsibilities of parenthood.

Of course, the responsibility for infant mortality reduction is not borne by the City alone. The State of Illinois shares this responsibility, and must make its own concerted efforts to protect the State's youngest population.

STATE OF ILLINOIS

At the state level, the Governor, the Legislature, and the relevant agencies can and should address the fiscal and economic factors that hinder care for needy mothers and babies. As a priority, the State should enact legislation to guarantee the availability of Medicaid coverage to all eligible pregnant women (without spenddown). Recent legislation in this area was far from adequate because it merely gave the Department of Public Aid the option to extend such coverage. It was not mandated.

The Department of Public Aid must also closely scrutinize and monitor the health care services provided via the Medicaid/HMO program. The Healthy Mothers and Babies Coalition has learned of many problems with the HMO program, ranging from unethical enrollment practices to negligent care of newborns. The failure of some HMO-affiliated hospitals to transfer high-risk infants to better equipped hospitals is often cited. The Department of Public Aid has a contract with private carriers to provide this service; the Department of Public Aid has a fiduciary and moral obligation to ensure that it gets what it pays for.

The State must also make a real commitment to streamline the more cumbersome administrative requirements of the WIC program. Further, the State should provide additional funding to serve a higher percentage of those eligible for WIC services. This move could reduce long-term costs associated with low birthweight, the leading direct cause of infant mortality. Currently, WIC can serve only 40% of those eligible for benefits.

The maturation of the IMRI network has enabled 19 poor communities to develop neighborhood outreach programs to ensure that each pregnant woman entered the system on a timely basis. The IMRI program is off to a good start. We are now at the stage where this program should be evaluated and expanded to allow for coordination between the various community programs and with subsequent medical care providers.

FEDERAL LEVEL

The potential for the federal government to lead the fight against infant mortality is great. However, the federal government shows no signs of living up to its potential. Legislation such as the Act for Better Child Care (Dodd, D-Conn.), which would provide states with funds to make child care financial assistance to working families with incomes up to 115% of a state's median adjusted income, is essential. The current so-called "Welfare Reform" proposals are, at best, inadequate, and, at worst, repressive and dangerous. It is time for Congress and the President to get serious about family issues. This is an issue that should be an integral plank in the platforms of both major political parties during the upcoming presidential election.

Chicago is not alone in its battle against infant mortality. The death of any infant is a tragedy. The chronic illness of a child is often a preventable sorrow. Nearly 13 million American children younger than 18 are poor today; nearly one in five American children live in poverty. These children are at risk. It is our obligation to protect them.

Thank you for the opportunity to appear before you today.

# # # # #

Chairman Miller. Thank you. Thank you very much.

Dr. Edwards, in reading press accounts of some of the problems of individuals seeking access to prenatal care in Chicago, Mrs. Scott's story does not sound very atypical. Is her story fairly common in terms of the time that people would have to give to get access to the system?

Dr. Edwards. Well, I think one of the points that I tried to make, there is no simple answer. There is no one dimension of the infant mortality program. What she has said is one of the very basic elements that should be in any health care program. I want to again emphasize the fact that infant mortality is not an indicator in itself. It is one of the indicators that the general issues about health, the general status of health in that community is bad, and is reflected through the infant mortality program.

Now, certainly I think in any community where you have all of the elements coming together, you are going to have all of the negative elements, such as attitudes that even some health-care workers have, working and living under stressful conditions, you are going to have all of the elements, the perspective from the infusion and invasion of the community by drugs, and overadvertisement of alcohol and smoking. Now in such an environment you have all of that, in reflecting on the accessibility of care.

Chairman Miller. I understand that. But given that background the individuals in that community who are still seeking that care, I just want to know, and I am not even for the moment beginning to pass judgment on the system, but it seems to me that from all accounts, you have a system that is just simply overwhelmed. I am not passing judgment why someone has to spend 9 to 4 there, but I know that if you are working in a marginal job, and you have to give up a day every month or every two weeks, or whatever it is, depending on the condition of your pregnancy, should you be working, that there are not many employers that will tolerate that.

Dr. Edwards. That is true.

Chairman Miller. And most employers expect you to go to the doctor, you come back in a couple of hours, and you go back to work. But if a person has to encounter that. I am told that in other clinics, if you are going in the evening, just to get a test to see if you are pregnant, you may wait 7 or 8 hours in the evening just to get—and again, for the moment, I am not passing judgment, because there are enough fingers being pointed everywhere. I am just trying to determine where we are in the delivery of the system, and all of the indications seem to be that here, when you have some of the services available, those services are overwhelmed.

We had another problem in Springfield, where none of the services even existed. But those are two different problems. But this story is not atypical, is it?

Dr. Edwards. I think that is—no, indeed. I think that the system is, indeed, overwhelmed. I think that any time that you have to take longer than two weeks to get a prenatal place or appointment, something is wrong. But the best instances in the public sectors, and even in some of the private sectors, four weeks and six weeks are not unusual.

We have developed a system in which we very carefully screen our patients so that any patients even bordering on high risk can get an immediate appointment.

But the system is overwhelmed with those who must depend on the public sector for care, and just the numbers themselves are just—given the type of care that we think these mothers need, in terms of just technical care, and what she has emphasized in terms of humanizing care, we are continuously promoting and developing that to respond to that. But that is still a problem in many instances and I am not talking about just public. I am talking about private, too.

Chairman **Miller**. Ms. Scott, when you talk to friends of yours, people in the community who may also be pregnant, are their stories—their encounters with health clinics pretty much the same?

Ms. **Scott**. The same as mine, yes.

Chairman **Miller**. What is their response to that? What are their feelings about that?

Ms. **Scott**. Well, that is—there are a lot of young ladies much younger than I am that are pregnant today, and that was pregnant when I was pregnant, and where they would not want to go to the clinic, because they know that they would have to be there—they was inexperienced on having children, and they would miss a lot of their appointments because they know what they had to do to be there, all day perhaps, and so they would just miss the appointments. They were young, inexperienced young women.

Chairman **Miller**. Ms. Artis, that is what you see happen? All these people just fail to show up for their appointments?

Ms. **Artis**. Not in our clinic.

Chairman **Miller**. Not in your clinic?

Ms. **Artis**. No. Because first of all, if you call today and say I need to see a doctor, we take you today. We do not put you off.

And then, too, we do not have all the papers that you normally have to fill out. You do not have to prove to us that you qualify to get into our system. So we do not have to challenge credentials. So they make the appointments, and maintenance is very good.

Chairman **Miller**. Did you have something to say to that?

Ms. **Scott**. Excuse me. I do not know where your clinic is or anything, but there is probably that the people that are coming to her clinic are in her neighborhood. You know, that makes it easier for them to get to that clinic.

Ms. **Artis**. Well, we have people from Gary, IN, from Oak Park, from Evanston, because we have absolutely no criteria for shutting people out. You would be surprised. They come from all over the City of Chicago to get there because, they say, that once they get there that we try very, very hard to show that they are people, and that is how we respond to them.

Chairman **Miller**. Let me just ask you something. You talk about the dehumanizing aspect of it. Now we make this all too complicated; there were others that testified this morning that between the people that have to see that they are qualified for the services, and the people who qualify them—and I am sure that this is not just the State of Illinois—and the last thing that we are finding out—not out of callousness, but just how we apply the services necessary to the pregnant woman, and just get on with it. It seems to me that we are so busy trying to figure out which category you fit into, that time just keeps working its way on and working its way on. We heard stories from parents this morning of tremendous lapses of time while people tried to figure out where the reimbursement was going to come from.

The whole thing seems to be so complicated that it is almost beyond our belief, and those who encounter that system, I believe.

Ms. **Artis**. Then you understand, though, you are working with a population, especially with these young girls, whose education is not that great. And they are coming in to a system, and you are saying, okay, these are the things you have to do. I talk with them, telling them how to get to the bathroom, go down the hall and turn to your left, they come back and say, where did you say to go?

I mean, you see what I am saying is that that is very, very difficult for them. And they are probably very frightened to death of the systems.

Dr. **Edwards**. I do not want you to leave here thinking that the majority of the patients are that way. The majority of the patients are not that way. I think that one of the problems that we have is that it takes a certain amount of time for a physician to see a patient, unless you are going to have a production line. Now, I think we have to realize that, and you can see any patient who comes in, is limited to the volume that can permit that. But when you are seeing hundreds of patients per day, and you are limited with reference to staffing, and you are insisting upon a certain quality of care being delivered to that patient, it is going to take time, and something has to be sacrificed.

One thing that we have helped, we want the patient to receive what they should receive at each visit, regardless of how many people are out there waiting. Because it is much better to give a patient quality care than to just give them a hit and miss, so that you can say I saw "x" number of patients today.

Chairman **Miller**. I am conceding that. I am told that in one of your hospitals, you have 100 people each day show up for a half day high risk prenatal care clinic, and you have got four residents and an attending physician trying to work their way through those people and, conceivably, the patient load is high risk, and it is still three to four weeks—again, I am not passing judgment, but I need to get some handle on what we have here, and whether we have not built a system so complicated that we—given the physician load—that there is a front-end loading here before you ever get to see the physician.

Dr. **Edwards**. That is true. We have usually, in allocating resources, those individuals who are not laying hands on the patient are the first to go. But usually you have some deficiency up front. There is a number of clerks you have answering the telephone, the number of clerks that you have that are properly trained. The salaries are so low, you are not going to get the quality of workers we would like to have dealing with these people.

So I think you have to look at the whole system up front, as well as——

Chairman **Miller**. That is what we are trying to do here.

Mr. Duffy, when are you going to come out with your new regulations on the expanded Medicaid coverage? You have been given authority by the legislature, is that right?

Mr. DUFFY. That is true.

Chairman MILLER. When is that going to happen?

Mr. DUFFY. As soon as I know what level of funding the general assembly of the State of Illinois is going to give me to fund that program. Unlike Congress, Mr. Miller, I have to operate within available revenues for a given fiscal year.

Chairman MILLER. Did you ask for coverage up to funding to cover 100 percent of the poverty level?

Mr. DUFFY. We are coming up to go through our budgeting process, and I will be asking for 100 percent poverty level—federal poverty level on these individuals.

Chairman MILLER. What do you expect that that is going to cost?

Mr. DUFFY. It is hard to say. I really do not know. There have been estimates as low as what Mr. Stermer said as $2 million, and go as high as $30 million.

Chairman MILLER. What is the discrepancy?

Mr. DUFFY. The discrepancy is the population we do not deal with today. So you do not have valid figures or valid figures on the numbers of people that will, one, access the service, and two, the number that will be available, or will be qualified for the service.

Chairman MILLER. In other states we are told that in those populations you find people eligible for these services at about the same random sampling as you would the difference between 50 and 100 percent or 70 and 100 percent of the people randomly spread throughout these services.

Mr. DUFFY. We believe that probably is consistent. And under those circumstances, we are looking at probably $10 million in federal money.

Chairman MILLER. Are you talking about 100 percent of poverty with the same reimbursement rate as you have today? $450—what do you do in the State? $450, or approximately $450 for a normal delivery?

Mr. DUFFY. I am talking about coverage up to 100 percent of federal poverty level.

Chairman MILLER. But would that be the reimbursement rate?

Mr. DUFFY. 100 percent.

Chairman MILLER. No, that is the population you would cover, but is the reimbursement rate you are going to the doctor going to remain $450?

Mr. DUFFY. That is correct. At the present time it is $450.

Chairman MILLER. With all due respect to your fiscal problems, there seems to be unanimous agreement that that reimbursement rate is not going to buy you services any longer.

Mr. DUFFY. Mr. Miller, with all due respect, I do not have the ability to borrow money from next year, either. I have to use what I have available this year.

Chairman MILLER. No, but I asked you——

Mr. Duffy, when you go to the legislature, you can ask to cover 100 percent of the people at a reimbursement rate that will not get you the services, or you can ask that the rate should be lifted to

$500 or $550, or I do not know. I am just asking, are you asking for both of those?

Mr. **Duffy**. That would be the decision of the governor when he presents his budget sometime in February.

Chairman **Miller**. Are you recommending that to him?

Mr. **Duffy**. Yes. Mr. Miller, you have to understand something. As I said before, I can substantially raise the rates today. That does not suggest that other physicians—in fact, there is information that suggests that no new physicians will come into the program.

Until we get a handle on malpractice here in Illinois, the significant problem it causes with a number of physicians leaving this field, you can put a lot more money into the system, but if there is nobody there to accept the money, and provide those services, it will not cost me a dime quite frankly, because there is nobody there to receive it. We need to figure out a way to resolve the malpractice problem, and bring the physicians in and address the higher rates at the same time.

Chairman **Miller**. I understand that, but by the same token it would appear that to do nothing until the malpractice situation is settled simply means that we are going to deny this coverage to the poor people in the State of Illinois. The rich people, the working people with insurance plans, they are going to get their premiums adjusted ten dollars a month, or four dollars a month, or whatever it is, $100 a month; and they are going to go on and get the service for their wives, lovers, spouses, or whomever, that become pregnant.

But poor people are just going to go without this service, and I do not think that medical malpractice can be the basis of denying poor people service in this State. And I am sure it is going on in my state. We are wrestling with the same thing in California. I mean, is that what you are telling us?

Mr. **Duffy**. What I am telling you, Mr. Chairman, is that——

Chairman **Miller**. That doctors and lawyers are holding poor people in the state hostage, is that what you are saying?

Mr. **Duffy**. I am not suggesting that doctors are holding poor people hostage at all.

Chairman **Miller**. Well, let me suggest it. You are saying that until you can come together on medical malpractice insurance, it does not make any sense to raise the premiums. You cannot get a premium today sufficient to buy the services, so I come back around the circle.

Mr. **Duffy**. Until we get a handle on it, I am afraid that is correct. I am afraid we are going to have to bring more physicians into the program so that there is access to quality health care for individuals. By merely raising the rates—and when I use the word merely, I am not suggesting that that is a minor issue. It costs a lot of money. But by merely raising the rates does not in any way suggest that more physicians will come into the program, thereby offering access to individuals for this much-needed service.

And I am not—please do not get me wrong. I am not trying to defend a practice that I believe to be correct. What I am suggesting here is trying to share a problem that all of us have, I think, some important solving and especially you, as Members of Congress, can assist us who have been not so successful in addressing the malpractice problem. Perhaps at the federal level you can be of assistance to us. I certainly would seek your assistance to do that.

Chairman **Miller**. Mr. Coats?

Mr. **Coats**. Jennifer, you seem to have developed a model that works. Certainly people, low income women, travel a substantial distance, take a quite a bit of time out of their day, at some cost to get there, because you offer something that the state system does not offer. You described it as an attitude of caring, an attitude of treating women as individuals. I wish you would describe for us a little bit more of how your program came into being, how it is supported, and how you think that you might be able to expand what you are doing, because it appears that this is something that is working.

Ms. **Artis**. How our program started, Dr. Eric C. Kast, an internal physician downtown, responded to the cutbacks which began in 1982. Dr. Kast had a number of patients who were on Medicare and Medicaid who could no longer get services. And Dr. Kast said, we cannot do that. We have to continue to see these people, whether we get paid or not. So what we did is we just rescheduled our fee scale, and some of these patients we did not even charge.

But then he went a little further. He saw people coming in who were literally not eating to pay their doctor bills. So he said, we are not doing enough. Let us take medicine to the community. It is a dream. He is 72 years old.

So we went out, and we just asked around, if they wanted a free clinic. And it happens that St. Basil's had a number of illegal Hispanics in the community and no medical care. The pastor there was very anxious for us to come into that community and provide that care.

We are staffed by all volunteers. Our physicians come from Loyola, Michael Reese, Mt. Sinai, support from Mercy, and some from County Hospital. Our staff: we trained community people, to run the clinics as coordinators and triage and laboratory technicians we brought the community people together asking if they wanted us to be there, and they said yes. On that yes, we said, then you have to participate in the clinic, in running it. You have to learn a task. And so they had to learn the technical measures, to count up pills, various things, to be a receptionist, answer phones, and what have you.

We attempted to provide services work, to insure that the patient got continuity of care. We carried from our private practice into the clinic the same one-on-one care. If the patient took an hour, the patient took an hour. We attempt to match each physician with seven patients an evening, so we do not have a Cook County situation where the doctor is overwhelmed. We provide free laboratory, free pharmaceuticals. We were able to go out and get a tertiary specialist who said, yeah, we can take patients in our office. For example, an optometrist will take seven patients per month downtown on Michigan Avenue. We have surgeons who will do surgery free of charge. I think that most people want to give, and they are all part of a system that does not allow them to participate and to give and to be compassionate.

Our patients sometimes come in and sit, and I will say, didn't I see you last week? But they come back, because of the fact that they know that we are accessible. They are not a number. I know them by name. The doctor knows them by name. They can call at any time, we have a 24-hour answering service. We are available to them, to go into a home, and give a call after hours. We are not someone who is going to be impersonally involved. And so that is why it works. It works because they know that it is an establishment who cares.

We take time during our triage, taking the vitals, to try to instruct them on hypertension and diabetes. We try to speak to the young girls about birth control the dangers, about choices. Those are the things that you have to do. But it takes time. You cannot expect success on a conveyor belt. It cannot be done.

And many times it takes a lot longer with one case than with another. We are in a community that is high risk cancer. And I have to say it. Health education is not for them. They have very little in terms of being able to say I can do this for myself. If I have a diabetic, we have to teach them to inject insulin. But it gives them a sense of being part of their medical care.

We explain the medications to them. What they are for. What happens if there are any adverse conditions. And they are able to come back to us and say, hey, this does not work. They are able to say, I am not quite sure that is the test I want, or why are the tests being given.

We do not want anyone to walk away feeling that we are just dispensing medicine as if it is an industry. We are not an industry.

Mr. COATS. Who pays for the lab work and the blood tests? There has to be some costs. There is a tremendous amount of volunteer support, but how is that part funded?

Ms. ARTIS. My budget last year was $17,000, and we saw over 8,000 patients.

Mr. COATS. Just a minute, I want to write that down.

Ms. ARTIS. Well, I have to thank the City of Chicago, they do an enormous part of our medical in supplying laboratory tests and supplies. They do the diagnostic,—Through Michael Reese Hospital, we have made arrangements that they do therapeutic laboratory work at a 40 percent discount. Reese gives us all of our x-rays free of charge. So our biggest bill are medicines.

Mr. COATS. Let me ask you this. We have to go back to Washington, and a number of the panelists here spoke about we need more money for this, that and so forth. We need to provide an adequate level of public assistance. But what we have seen is that often no matter how much we provide, we miss out on two of the three essential elements that Dr. Edwards talked about. Because you said there are three problems here. Some of the things that you are getting at have to do with lifestyle and socioeconomic systems that institutionalized programs do not seem to get to. And I think that the mistake in making the argument that we need more money for this or whatever, is that no matter how much money we provide, our facilities provide, if we do not provide those other essential elements, or deal with those other essential elements, we are never going to really get at the problem. And so, what would you recommend to us, in terms of injecting those elements that you provide into institutionalized programs?

What would you do? What would you tell us to do? What would you do if you were expanding? How would you expand this concept.

Ms. ARTIS. What I would do if I had an opportunity, would be to establish smaller community-based clinics. Because people go to what is close and what is familiar. And you are trying to get the community to participate in their own care. For example, we needed a diet for a a diabetic. We contacted a hospital for an appropriate diet, but in the community, the diet is not going to work. Because in that kind of store, they are not going to have fresh vegetables and fruit. It is too hard for the person to pay for. And that diabetic has always had fatback and greens in his diet, it is not relevant. But if you can get a group of community people together, they will say, what are we going to do? We have got a diebetic, let us work out a diet.

We should see results. They will invite each other to talk and identify health issues that affect them. You have viable programs so that they will come together because it is for their health, and they will want to do it.

You cannot conquer their fear with I am the doctor, I am the medical specialist. It does not work that way.

I would establish preventative programs. You would be surprised that a mother with a baby with a fever of 103 at 11 shows up at our clinic at night. Where has she been all day long? You are going to have to educate her as to what she can do to bring that temp down. Because she is not going to take the baby to an emergency room. Because it is too far. So it is simple. Provide her with other mothers. Someone in the small community.

Now, we are talking basics, and you are talking about money. We can get it to them, but not at the level where it would make a big difference.

If you cannot get people involved in taking care of their own health, all the money in the world is not going to work, because they still are outside of themselves.

Mr. COATS. Thank you for your response to that question.

Emma, you said in your testimony that you described a really unfortunate experience with your first child. You said, "I am really glad I was able to have the baby someplace else". What did you do with the last baby that you did not do with the first four? What was available to you?

Ms. SCOTT. Well, my first baby was born in North Carolina. Jacksonville, NC. My husband was in the military at the time, so I had the baby on a military base. My second baby I had at Michaelis Hospital. I was on public aid at the time, and I had a private medical room—not a private room, but just me and another patient was in the room. I had my own bathroom. And that is what I mean by having it in a nicer place.

Mr. COATS. And so this child you were talking about was at a time in your life when there was not any——

Ms. SCOTT. There was no——

Mr. COATS. No military assistance or public assistance at that time.

Ms. SCOTT. My life is still that way. And I can understand that the Department of Public Aid gave me a medical card to pay my medical bills at the Cook County Hospital once my baby was born,

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but they would not give me a medical card so that I could go to any hospital before my baby was born.

Chairman MILLER. Mr. Durbin?

Mr. DURBIN. Director, Duffy, this morning in Springfield we had a number of witnesses and doctors testify, and I might have to tell you candidly, but I think they might disagree with your conclusion. That the difficulty we face with infant mortality has a lot to do with the fewer physicians and providers that are available. I can see that the malpractice crisis is putting a crunch on it. Even in Springfield, two obstetricians have dropped out of practice. But that still leaves us with about 20 to 22 obstetricians in the community. Only seven of them will accept Medicaid patients or uninsured patients. When we asked the doctors for the reasons why they would not accept them, malpractice was mentioned, but it was mentioned in the general context of their practice. They had to raise everyone's charges in order to come up with the compensation needed to pay the new higher premiums.

But they did say, and I think it was very clear, that the level of Medicaid reimbursement now coming through our Department of Public Aid in Illinois is just too low to compensate them. It is about a third of what they charge other patients. I think you addressed this in your testimony that you are trying to improve the situation, but clearly it still presents a problem.

The spend down figures, which the Department is applying are unrealistic. They are falling on people who would make somewhere around $1,200 a month gross salary to spend down about $1,400 every two or three months, which is impossible, for a family of six, which is the example that was given this morning.

They talked about cross-referrals, where a doctor might, in fact, see one of the patients under their care go off to another doctor for a cold, while—during the pregnancy, and that would be deducted from the amount they receive from Public Aid. And finally, they said that the actual reimbursement that they are receiving from the Department of Public Aid just is not making it.

So while I sympathize with you on your comments about malpractice, I really think one of the bottom lines we heard this morning is that until the level of reimbursement reaches a point where Mrs. Scott and others are in the mainstream of care, then they are going to keep running into the roadblocks that are being thrown at them.

Mr. DUFFY. Mr. Chairman, I cannot sit here and argue with you and suggest that $450 is enough to cover a physician's cost at the present time, to provide OB or gynecological care at the present time. I am not so foolish as to think that anyone is going to believe that.

Some of the issues you raised is with regard to cross-over care. I have issued the change in the rule so that it no longer applies——

Mr. DURBIN. Good.

Mr. DUFFY. So that if, in fact, an individual who was receiving OB care happens to have another medical problem, that problem will be paid for separately, rather than part of the OB care. That was an old rule that needed to be changed, and I took the appropriate action to do it.

Mr. **Durbin**. Is it true that you compensate for C-sections $75 over the regular care?

Mr. **Duffy**. I know it is something around $75.

Mr. **Durbin**. And the ordinary charge is about $500 for a private patient?

Mr. **Duffy**. $16——

Mr. **Durbin**. I am talking about add-on, to the regular delivery? That is the testimony that we got this morning, too. It just seems to me that it is unrealistic. The compensation levels are not going to attract doctors to bring in mothers who are on welfare or uninsured. There is just no way they are going to be brought in with that level of reimbursement.

Mr. **Duffy**. Mr. Durbin, as I said before, I understand that. We recognize the responsibilty to increase access, to provide better care and better services to the individual. But you have to have the available resources to do that. And believe me that is a priority. We will work on the priority.

Mr. **Durbin**. Well, I might add that being a resident of Illinois as some of us here are, we are very aware that Governor Thompson went to the legislature and asked for a tax increase. And I am sure if he had been successful, our discussion would be different here this afternoon.

It is very clear to me that that is part of the problem you face and will continue to face until it is resolved. It is true, too, that we are dealing with a deficit in Washington, one that we are trying to pare down, but still is pretty illusive. But when we do things like enact the optional Medicaid expansion provision in SOBRA, we were willing to pony up half the cost. The Federal Government said, we will pay half of it. Come on, State of Illinois, join us. And about 24 States have joined us, but the State of Illinois has not.

Mr. **Duffy**. Yet.

Mr. **Durbin**. Yet. But for you to suggest we have to wait another year, when we are living in the state with the highest infant mortality rate in the northern portion of this Country, that is a little unsettling. We are truly going to lose lives while we wait. And I think that was the testimony of the witnesses here in terms of what this costs. The actual cost of inaction is going to be stillborn, babies born with diseases and disabilities, which are going to cost us for the child's lifetime.

Mr. **Duffy**. How do you react to that, Congressman?

Mr. **Durbin**. I am waiting.

Mr. **Duffy**. Would you like me to say something to the group out here, or—frankly the hardest thing is—I agree with you. I cannot argue those points. I am not going to attempt to argue those points.

The bottom line is yes, as Congress has the legislation, I agree. It makes absolute sense to get to the very heart of that—two reasons. One, it is probably the most humane and most reasonable thing to do from the respect of caring about our fellow human beings. But from the second perspective of Mr. Stermer and everybody else who has testified here today, the obvious costs are going to be substantially lower in terms of caring for individuals who are developmentally disabled, or who have some other problems as a result of having no access to health care. And we will move in that direction.

I just do not have the ability to implement a new program today that I have not got the money to fund. The State constitution is not allowing me to do that. We sit in Springfield for two or three months, and use every available reason and plea to raise additional finances for this department, to fund these programs. They cut my budget. And the Illinois Senate, by over $300 million in medical programs alone for the upcoming year. I will leave this fiscal year with over $400 million in medical debt. Delaying payment? You are absolutely right. And it is going to get worse. I do not have the ability to go forward with it until such time as they give me the resources. I would love to pass it. I would love to implement it. But when I do, I have got to figure out a way to pay for them.

And until such time as we can all work as a unit, and say yes, and move toward that to resolve these problems, then I am afraid I cannot cover these programs.

I am not giving you excuses. I am giving you the reasons I cannot do it.

Mr. **Durbin**. Dr. Edwards, is it correct that Cook County Hospital is the only hospital taking nonpaying prenatal patients in the City?

Dr. **Edwards**. No, indeed. I mentioned our Partnership in Help Program, in which we have signed contracts with a number of hospitals that relate to our help centers, and these hospitals will, indeed, accept patients from us and will attempt to obtain some third party payers, and if they are not successful, and we come in with their minimum fee and pay that.

And also, they will accept non-maternal patients who have no source of payment. So we are beginning to improve the system through the Partnership program, and we hope to extend it. And we are beginning to place the patients in the neighborhood, as this young lady said, is a very key part.

Mr. **Durbin**. Do these hospitals also take high risk patients?

Dr. **Edwards**. No.

Mr. **Durbin**. Cook County is the only hospital that does?

Dr. **Edwards**. No. There are several others.

Mr. **Durbin**. Nonpaying patients?

Dr. **Edwards**. The high risk patients who were financially taken—until this year were financed by the perinatal system financed through the State. And that reimbursement, as I indicate in my written testimony, was not sufficient in many instances to receive these patients. And so, Cook County receives other pay. The bulk of these patients. Some of these patients are, indeed, transferred from perinatal centers to Cook County hospital.

Mr. **Durbin**. Mrs. Scott, did you say that you were classified a high-risk pregnancy with one of your children?

Ms. **Scott**. Yes.

Mr. **Durbin**. At Cook County Hospital?

Ms. **Scott**. Yes.

Mr. **Durbin**. Is it your testimony that it took a month?

Ms. **Scott**. For my first appointment, yes.

Mr. **Durbin**. And at what stage of your pregnancy were you?

Ms. **Scott**. I would say about eight weeks pregnant when I made that appointment.

Mr. **Durbin**. Doctor, do you think that is an acceptable period of time to wait?

Dr. Edward. I think I said—I said in my testimony that it certainly is not. And we frown very heavily upon that.

I think here again, and I was at Cook County for a number of years, the system is overwhelmed for the physicians and the number of patients seeking progress or care. There was an attempt to triage those patients so that those who were high-risk did not have to wait a month, but I am sure in some instances that could have happened.

Mr. **Durbin**. Thank you very much, sir.

Mr. **Hastert**. Thank you, Mr. Chairman.

I first want to respond to—make a comment to you—your program, and I hate to pass this off. You said you had—we sit here in a chair, and we sit on a Committee, and Mr. Duffy said he asked for money, and he said he had a problem, it was tough, because when you talk about money, you say, well, we match this federal program and we make it happen, but what do we cut? Do we cut out elementary programs or higher education, or sciences of the '80's or where? It is not a fun business sometimes to make those decisions.

But you are talking about a program—how many people do you treat in a year? About 12,000 people?

Ms. **Artis**. Yes. We treat about 8,000 people. We have 8,000 patients on the rolls.

Mr. **Hastert**. At a time. In the sense, right? And you had a budget of $17,000?

Last year. I think we can take a lesson from you to tell you the truth. But as for the present, I think the point is that we are talking about dollars and increase, and you are talking about an element that is not measured in dollars and cents. And I am not sure how we get what we are talking about to what you are talking about. It is difficult. And it takes a special type of people.

Let me just ask you a couple of practical questions, and then we will move on.

We heard this morning that children that are—or mothers who are working—an underclass, poverty level, certainly have high risks. I think all of this here can prove that out. People, especially in the big cities and downstate Illinois, among the Black population, and Hispanic population are even in greater peril or risk. And the children that they have certainly in the process of birth, that the risk of those children—they are underweight, they die, they are going to have risks, deformities, that are very expensive.

You are willing to volunteer your time. Do you have any insurance? Do you have any—do you have any protection against somebody coming back at you on a legal basis?

Ms. **Artis**. Yes. We went to Michael Reese Hospital, legal department, and they said as long as we do not accept any money, we fall into the coverage of the Good Samaritan Act—because the patients would have to prove that we intended to harm them. And to date, we have not had any patients sue in that way.

Mr. **Hastert**. That is the relative piece of legislation that is passed now.

Ms. **Artis**. Right.

Mr. **Hastert**. Quite simply, then.

How can you—how can we appeal to more people to do things like that—your organization? Is there an incentive that you use for these doctors to say, hey, maybe the best way to do this is to give some things free and alleviate the problem for everybody.

Ms. **Artis**. Most of our doctors say that the clinic allows them the opportunity to practice medicine, whereas in most of the hospitals they are not allowed to do that. Because the rules are in place, and in some of the rules, you must see a patient in 15 minutes. You have to get them out of there. It is a cost containment program. In the HMO, move them through.

Here, they do not have those constraints, and they have time to see who the person is that they are working with.

Mr. **Hastert**. Let me throw something out. Maybe I am way off base and should not be talking about some of these things, but is there an incentive that you give people? Do you give tax credits or something like that for volunteering time?

Ms. **Artis**. Most definitely. You have to understand. We run four nights a week, Monday through Thursday. Monday nights have the same doctors. Tuesday nights have a different set of doctors, but it is the same doctors every Tuesday night. And I do not have to pick up a phone to ask them to come. I do not have to ask the volunteers, if they are coming in. They are there because they want to be there. Because they really feel that they are doing something, and a tax incentive, or something would certainly help us out. I think it would get us more doctors, because we are certainly—we need the doctors.

Mr. **Hastert**. I appreciate the time, and it is very creative. A breath of fresh air, some of the things you are doing.

Mr. Duffy, on your testimony, and I want to touch this one more time about malpractice insurance, and the support system in the State of Illinois and you made a point. I just want to ask you one more question on that.

It seemed from the testimony that we had this morning that we give—the doctor receives $1,000 to deliver a baby. We had testimonies that some doctors in the State of Illinois said that $1,000 and that is all the business before and whatever happens afterward for whatever period of time. You are given the $450 if there are no complications. Do you see it that the expense of doctors—it was your testimony this morning too, that—do you see the doctors in their trade that office expenses and insurance costs are $200 to $300 per patient, and they have to do a lot more tests, and it is more expensive to deliver a baby than it used to be. They do ultrasound, but we did not have ultrasound 15 years ago, as they said. They are doing one or two or three. And they give tests for all kinds of consolations. They have to do these things to make money—there are money making quarterbacks out there who are willing to take them to Court. Do you see ways that the system could be fixed so that number one, maybe we can hold costs where they are, and number two, we do not have to have doctors overpractice medicine?

Mr. **Duffy**. Well, Mr. Hastert, I think that probably what they were referring to—and I was not there, and I apologize, but the problem—probably what they were referring to was the issue of physicians attempting to overcompensate for the number of suits that they get themselves involved in on an annual basis as a result of allegations of malpractice. And what their attorneys have told them to do, outside of the bounds of good medical practice, although it is not bad medical practice, but outside the bounds is to go beyond what one would typically consider to be good care in order to protect yourself through that pregnancy, or through that delivery of care, so that you can establish a defense at the end in case there is a malpractice claim.

In other words, you spend a lot more money throughout that care because you are attempting to provide some sort of a defense for yourself at the end.

Certainly, it would be much less costly for physicians if they did not have to do those things. In situations where it is a high risk pregnancy, it makes absolute sense to do those things. In fact, oftentimes go beyond those things.

I think the key here is for some reason we have gotten beyond what the doctor is there for. I mean, look at the number of malpractice claims that are filed annually. There are frivolous malpractice claims that are filed annually. Each time one of those is filed, it costs that physician enormous amounts of money, both to defend him or herself, as well as in their malpractice rate because of the number of claims they have against themselves. It is a system that is cyclical and eats upon itself, and frankly, until such time as we get a handle on it, even if I were to raise the rates, I will take you down to areas in Southern Illinois, Congressman, where not one more physician is going to enter into the program.

The basis behind the Medicaid program, and if you were in Congress back when it was passed, and I believe you were, at least pieces of it were passed, was to provide access to the mainstream health care system for the indigent. Those that qualified under the Medicaid program. Not to create Medicaid physicians, but to give those individuals opportunities to go in—to go to the same physicians that those with third-party coverage and their own coverage provided.

In Southern Illinois, specifically, down in the area of Congressman Durbin, where you do not have such a high concentration of population, physicians cannot afford to be public-aid only physicians like we have here in Chicago. When they drop out of the system, they do not just drop Medicaid, they drop entirely out of the system and go to Indiana, where the rates are probably one-quarter to one-fifth what they are here in Illinois, where in some other state where it is much easier to practice.

It is a serious problem. A very serious problem. We have raised our physician rates, believe it or not, to the $450 level in the past 4 or 5 years. It has actually mirrored inflation in Illinois. We did not come in and establish this problem. We have inherited it. I mean, every year we have put more money into the system, with the exclusion of this year, of course, since we did not get the revenue. But until such time as we get a handle on both, we are not going to resolve this problem.

Mr. HASTERT. Thank you.

Mr. Stermer, it is good to see you again. I do not know how many years it has been. And I know you are trying to put together a number of solutions to the problems. First of all, let me ask you a question. You are in the Voice of the Children. Do you see a reality in terms of the bureaucracy and public aid, and the system and all the problems, and the solution to the problems that Ms. Artis was talking about—do you see any real ground? Do you see any way we can get from A to B; is it possible?

Mr. **Stermer**. I think that we need to address the many problems that Director Duffy alludes to. One of the things that I think that Congress is grappling with is the possibility of completely decoupling welfare from medical services so that we can get away from what Ms. Artis is talking about. People go in and are deluged with paperwork because we have to really go after the income guidelines, whether we are in 100 percent of poverty or the current 133 percent of AFDC that we do.

I think we need to just say that pregnancy is something that we care so much about that we are going to provide public financing for pregnancy-related services. That does not completely address the middle ground but I think that is one thing that we have got to get to, because I think that there certainly is the administrative costs of a lot of the red tape problem.

Congress, I think, has grappled with whether a pregnancy per se ought to be a category for medical services. And I think both Congress and state legislatures ought to think about that, because of the outlying costs of not doing that.

But is there a middle ground? I think Director Duffy talks about not just how we treat people, as Ms. Artis talks about, but how we treat providers, and I do think that the questions of malpractice have to be addressed along with the reimbursement and along with the eligibility for people. I think all three of those things are important.

Mr. **Hastert**. Thank you. Thank you, Mr. Chairman.

Chairman **Miller**. Mr. Hayes.

Mr. **Hayes**. Thank you, Mr. Chairman. I will be very, very brief. I recognize the time constraints that you are operating under, and I am sorry to be barging in here. I want to say to Ms. Jennifer that you raise a dimension that I think is really a factor that we have to consider. We are dealing with human beings, both the mother and the child here. If you recognize that, I think this is a big step in the right direction. And Dr. Edwards, I know you know that.

I think we have to first approach it from the point of view that this is an issue that is non-Partisan.

When you talk about Parents Too Soon, as you do in your statement, Mr. Duffy, this is one of the major contributing factors to the whole issue of drop-outs that we are trying to deal with when we talk about the issue of education. Young mothers are dropping out of school because they become pregnant. I hope we can get the legislation, and I hope we can get the kind of support we need to get it passed to deal with this problem. The high-risk students who drop out of school because they become pregnant, try to get them back in once the baby is born. But then there becomes a problem of how you care for that baby—that child.

The State of Illinois has committed to spend, in your statement, $13.5 million during the fiscal year of 1988 for this Parents Too Soon program which makes it one of the most generously supported programs of its kind in the Country. Now, if you could just briefly tell me what is the method of distribution of those funds? How might I expect to get some of this in my area, the first Congressional District, which is predominantly Black. This is where we have a great problem on the question of parents too soon. You know, Teenage pregnancy. How is this money going to be distributed? How is Chicago going to make sure it gets its share?

Mr. **Duffy**. Do you want me to respond to that?

Mr. **Hayes**. Please, if you will.

Mr. **Duffy**. For the most part, most of the money that we spend on the Parents Too Soon program is done with the partnership of the City of Chicago, in which we take their needs, and try to identify community agencies that are most involved with preventive effort toward stopping kids from having kids. I cannot tell you the exact location of these programs, although we do have—for example, in two of the high schools, we have clinics which we made a clause to come under some controversy recently, that are part of that program that are working toward the reduction of kids having kids, along with the community and under their guidance.

I would be more than happy to provide you with a list of the facilities—the organizations in your area that are presently a part of the partnership of Parents Too Soon.

Mr. **Hayes**. Dr. Edwards, you mentioned the fact that Chicago, all we have got to do is ask. Do I see you first?

Dr. **Edwards**. No. Not the Department of Health. No. We cooperate in that program, but we do not lead in it.

Mr. **Hayes**. You may need to supply me with that list of locations.

Mr. **Duffy**. I would be happy to—again, I need to state that we do not fund the City to do it. We work along with the City to identify community organizations. We would rather spend money on the programs, Mr. Hayes, than put it in the governmental agency, and the city is working along with us to choose the right organizations to help deliver that program.

Mr. **Hayes**. A lot of these funds usually get lost in administrative costs, you know, rather than programmatic costs.

Mr. **Duffy**. We are very pleased with our relationship with the City and how they administer dollars as they were to go through the City. This is one of those programs that do not go through the City, although we do, as I said, work with them in a partnership—a cooperative partnership to ensure the organizations that we do finance or fund are providing the necessary services.

Mr. **Hayes**. Thank you, Mr. Chairman.

Chairman **Miller**. Thank you. Thank you very much for your testimony this afternoon, and the help you have provided the Committee. We appreciate it.

The next panel that the Committee will hear from will be made up of Gertrude Washington, who is Project Director of the Austin Infant Mortality Network; Maria Brown, the Chief Resident/Fellow of Cook County Hospital; William Weigel, who is an ostetrician; Eugene Perkins, who is a Social Services Director in Chicago; and Carmen Velasquez, who is a Board Member of Project Alivio in Chicago.

We will include your written statements in the record in their entirety. You may proceed in the manner in which you are the most comfortable. I am informed that we are going to have to vacate this facility in about 45 minutes, and so the extent to which you can summarize your statement, we will appreciate it.

So, Ms. Washington, we will start with you.

STATEMENT OF GERTRUDE WASHINGTON, PROJECT DIRECTOR, AUSTIN INFANT MORTALITY NETWORK; CONVENOR, CHICAGO COUNCIL ON THE INFANT MORTALITY REDUCTION INITIATIVE, CHICAGO, IL

Ms. WASHINGTON. Thank you, Congressman. I am more than glad to be here, and I am also glad of your agreement not to go over my written statement. Because as I sat through I started changing my statement, and I recognize that even though much of this Nation is getting there, it talks about the ten networking agencies that are here, and whom I represent, one of the things that we need to make sure is acknowledged and understand is that much of what Jennifer Artis' has spoken of, we are part of the community resources, and we address and identify and work with community people.

We recognize that community people know what they are talking about, but they do not always have the answers. And even sometimes when they have the answers, they do not have the funding. And through the community networks, much of our efforts in the first year have been focused on making sure that we put a bridge between the social services or the health services, and how to get people to access those services.

Our uniqueness is we have, over the year, found out that we do not know all that we need to know about who is receiving what funding where. And many times agencies that are federally funded, state funded, some of the different agencies do not acknowledge or recognize us, meaning the Infant Mortality Networks as being a viable network of services whom they need to utilize.

We have, through each of our networks, resources. Community hospitals, community social services agencies, community pools, community employment training programs which we have been working with to begin to recognize if there is a problem how they can come through our system and make sure the client receives all the services they need.

Because there has not been a clear linkage in the city and us in the local community, we continue to battle. But I think we have made great strides. I heard earlier the statement and discussion around physicians in the City of Chicago and the State of Illinois, and who was providing what services.

I would like to state that we have found, and particularly, I want to say that I have found in our communities that we are having problems with doctors who are not on hospital—they do not have hospital privileges. And therefore, our clients go to those physicians, they see them, they think that they are accessing quality health care throughout their pregnancy only to find out at delivery as they go to the emergency room that there is no doctor there to attend to them.

What happens is that we then receive information on the problems that are incurred through the hospital themselves. And in my particular community, in Austin, there is no High Risk Hospital. St. Anne's is the only hospital that is really accessible. Austin is four miles long. Much like many of the other communities—the 19 other community areas, the large vast community populations that do not have high risk hospitals to provide services for those clients. As a result of that, those clients then end up being discharged from the hospital and getting back into the system after they have delivered, and after they have encountered a number of problems. I do not know yet all of the answers. We do, naturally have recommendation in terms of what we think should happen.

And one of the things is that we think we need to get a handle on who is providing what kind of OB, obstetrician services to the clients within any community area. We also need to have some way of being able to say that those doctors are not able to just utilize all of their patients, medical payments up during their time period and then we reimburse at the rate that is best. Rather than the rate is too high or too low, we now have people that are just basically abusing the services out there for the hospitals to the physicians.

Other than that, I think that we have identified through the networks themselves, we have some continuing problems that we perceive as needs. And one is funding. And we all know that funding is important for any program to operate. Unfortunately, unlike Ms. Artis' program, we do not have total volunteers. All of our agencies that work with the programs are volunteering a percentage of their time because we are not able to reimburse them at a rate that they would normally be reimbursed at. But we need to make sure that the funding level is kept at such so that there is an ongoing quality assurance around case management of those clients that have been identified, and providing them with the health services as well as the social services that they need.

We also recognize that there needs to be a development of strategies to address the socioeconomic barriers that impact infant mortality and infant morbidity. Not only are we finding that there is a need for regular health care, but how do we as a community network address the issues of housing? How do we address the issues of unemployment? Because we recognize that many times the level of the clients that we are working with are not high school graduates, but they need some kind of assurances, some kind of mechanism that will ensure them that they will be able to raise the level of their lives for their children.

And I do not think that any of the clients that we see want their children not to do better than they have done. I am asking that this Committee look not only at this report that we have submitted, but as you go back to Washington, call us sometimes. We do not mind giving you input in terms of what is happening in our community. And I agree, you need the humanistic point of what is happening out there as the service providers, not the bureaucratic parts of it. But we, as service providers, we work with the politicians.

We work with the community people, we work with the physicians, and the hospitals, and so therefore we need to know that you are willing to call and give us some feedback when we write those opinions.

Thank you.

[Prepared statement of Gertrude Washington follows:]

PREPARED STATEMENT OF GERTRUDE WASHINGTON, PROJECT DIRECTOR, AUSTIN INFANT MORTALITY NETWORK; CONVENOR, CHICAGO COUNCIL ON THE INFANT MORTALITY REDUCTION INITIATIVE, CHICAGO, IL

Good afternoon. My name is Gertrude Washington. I am the Project Director of the Austin Infant Mortality Network, Habilitative Systems, Inc., 4958 W. Madison, Chicago. I am submitting this testimony today as the Convenor of the Council on IMRI which consists of Project Directors and Advisory Board Chairpersons from the Chicago Families with a Future funded projects.

There are ten Families with a Future projects in Chicago: Englewood Quality of Life Network; North Lawndale Network; East Garfield Network; Austin Infant Mortality Network (AIM'N); Family Life Organization; Southside Infant Health Network; Humboldt Park; Westside Futures; West Garfield Network; and Visions for Life Network. The Lead agency for these network is the Chicago Department of Health.

The infant mortality rate in these communities in 1985 was 22.0 deaths per 1,000 live births, 33% higher than the infant mortality rate for all Chicago's residents. These communities accounted for half the infant deaths in Chicago in 1984, even though they represent only 19 of the 77 (25%) of the communities in the City. Infant deaths totaled 434 in these 19 communities in 1985 out of 896 deaths in all of Chicago.

Between 1982 and the close of 1984, Chicago's infant mortality rate declined at a rate twice as fast as the nation and 30 percent better that the State of Illinois. The rate in 1984 reached an all-time low of 16.4. This means that in Chicago we now are saving three more babies a week than we did in 1982. The new rate, established in 1985, is 16.5 deaths for every 1,000 births, suggesting a leveling off in the decline.

The rate for blacks (22.4) is about twice that for whites (11.3). Data suggests that the high incidence of low birthweight babies (under 5 pounds) among blacks is responsible for this difference. Although only 10.1% of all babies born to Chicago residents were of low birthweight in 1985, this group accounted for almost 70% of all infant deaths. In 1985, the risk of low birthweight among blacks (14.4) was more than two times greater than among whites (6.1).

Data indicates that five Illinois cities now have higher infant mortality rates than Chicago: Chicago Heights, East St. Louis, Harvey, Kankakee and Waukegan. The overall state rate for 1985 wass 11.6. Since the mid-sixties, Chicago has held the unfortunate distinction of having one of the highest infant mortality rates in the nation. Using 1984 data, Chicago's rate is over 50% higher than the national rate of 10.6. Its rate of 16.4 compares as follows: Washington, D.C., 21.2; Detroit, 20.8; Atlanta, 19.3; and Clevland, 16.8.

Over the past year the above networks have developed community-based programs which provide case finding, case management services focusing on low birthweight prevention. Efforts focused on client education, referrals to appropriate resources, health care monitoring, tracking and follow-up. Much time and effort during FY'87 was spent on developing the networks' structured components and on developing relationships with subcontractors, Community Network Coordinating Entities and advisory boards. Because of the uniqueness of the community network concepts, procedures and divisions of responsibility/liability had to be addressed and developed. The networks would like to state that much progress has been made in developing a workable structure.

The concerns of the Network Council are as follows:

- Continued funding at a level to insure ongoing case management and health services for all networks.
- Implementation of policies to insure patient care funding and provisions for services from state, city and local agencies receiving infant mortality funding.
- The development of a strategy and procedures to address the socioeconomic barriers which impact infant mortality and morbidity.

Chairman **MILLER**. Thank you. Dr. Brown.

STATEMENT OF MARIA I. BROWN, D.O., CHIEF RESIDENT, FELLOW; DEPARTMENT OF FAMILY PRACTICE, COOK COUNTY HOSPITAL, CHICAGO, IL

Dr. **BROWN**. Good afternoon. First, let me tell you that I speak today of my personal experiences. I am not authorized to be a representative of Cook County Hospital.

Let me then tell you a little about who I am. I was born to uninsured parents in the City of Chicago at a time when $200 covered the cost of prenatal care and a private hospital allowed my mother to be admitted.

Today, I am a Board-certified family physician at Cook County Hospital, where I also completed my residency. As a comprehensive provider of health care services, I often encounter pregnant patients. My patients are the urban poor. Many are young and do not receive prenatal care until late in their pregnancy. They are at high risk for having low birthweight infants, just by nature of their socioeconomic status.

Let me tell you about three of my patients who are typical of the pregnant women I care for. Their names are changed, but their stories contain the essence of what the needs are here in Cook County.

Mary was a 14-year-old who first appeared in my clinic on a busy afternoon, in her 28th week of pregnancy. She had received no medical care, and was terrified to tell her family about her condition. Later she told us a family member was the father of her child. She was withdrawn and frightened beyond words. In a very limited time available, I began her prenatal work-up. She vanished for seven weeks, during which time I phoned her home over a dozen times, often speaking to a variety of angry family members.

When she did return to the clinic, she spoke haltingly with a very overworked health educator and me about her history of physical and sexual abuse. Through the untiring efforts, and I do mean untiring, she worked well beyond the 9 to 5 day, weekends, personal time, our health educator in the Department of Health and Family Services, she was placed in the home of an aunt and enrolled for counseling for both abuse and teen parenthood. She delivered her infant and completed the eighth grade.

Mary is a success, and I think she will continue to be, but she needs ongoing, accessible care from trusted providers. I think of her often, and I wonder how many young ladies just like her are falling through the cracks of an overloaded system. She is not unique, either in terms of her need or her courage.

Sue was a mildly retarded mother of three, each of whom was born 11 months apart. She can neither read nor write, but this is not immediately apparent to the observer as she is quite socially skilled. Her eldest two children were sporadically attending my clinic when she discovered she was pregnant again. Her husband is employed as a fast-food worker, and they have no insurance.

Sue has a history of premature deliveries in the past, and at the time of her last delivery, she did not tell anybody she was having contractions, although she was on the ward, hospitalized for preeclampsia, until the delivery was imminent.

During her pregnancy, a truly herculean effort was undertaken by our clerical staff to ensure that if she did appear in clinic, she would be seen by someone even if she could not elucidate what her needs were or why she was there. Her pregnancy was quite stormy. It was complicated by premature labor, poor weight gain, and infection.

Beth is a 27-year-old woman who travels one hour or more on public transportation to receive free care in my clinic. She works full-time as a waitress, and has no medical insurance and does not qualify for public aid.

She worked up until the day of her delivery, at which time she took two buses and a subway, during rush hour, to Cook County Hospital. During her pregnancy, she had a difficult time with her employer, as he objected to the amount of time she needed to spend coming to and waiting all day in my clinic. This frequently resulted in missed appointments.

Four weeks after the delivery of her infant, she was again working full time to support her young son, for whom she has many aspirations.

Gentlemen, thank you for your attention to my testimony. I am just one physician in a huge system, and there are thousands of stories. The need is great. The resources are sparse. Let us not blame the victims for this, but let us work together to improve life at its start for all our citizens.

[Prepared statement of Maria Brown, D.O., follows:]

Prepared Statement of Maria I. Brown, D.O., Chief Resident/Fellow; Department of Family Practice, Cook County Hospital, Chicago, IL

Good afternoon, ladies and gentlemen. Let me tell you a little about who I am. I was born to uninsured parents in Chicago at a time when $200.00 covered the cost of prenatal care and a private hospital allowed my mother to be admitted without insurance.

Today, I am a board certified Family Physician at Cook County Hospital, where I also completed my residency. As a comprehensive provider of health care services, I often encounter pregnant patients. My patients are the urban poor. Many are young and do not receive prenatal care until late in pregnancy. As I'm sure you know, they are at high risk for having low birth weight infants, just by nature of their socioeconomic status.

Let me tell you about three of my patients who are typical of the pregnant women I care for. All the names have been changed. I feel their stores contain the essence of what the needs are here in Cook County.

"Mary" is a 14 year old who first appeared in my clinic one busy afternoon in her 28th week of pregnancy. She had received no medical care, and was terrified to tell her family about her pregnancy. Later, she told us a family member was the father of her child. "Mary" was withdrawn and frightened beyond words. In the limited time available I began her prenatal workup. She then vanished for seven weeks, during which time I phoned her home over a dozen times, often speaking to a variety of angry family members. When she returnd to the clinic, she spoke haltingly with our overworked health educator and me about her history of physical and sexual abuse. Through the untiring effort of our health educator and the Department of Children and Family Services, she was placed in the home of an aunt and enrolled in counseling for both abuse and teen parenthood.

"Mary" is a success but she needs ongoing, accessible care from trusted providers. I think of her often and wonder how many young ladies like her are falling through the cracks of an overloaded system. She is not unique either in terms of her courage or her need.

"Sue" is a mildly retarded mother of three, each of which was born 11 months apart. She can neither read nor write, although she is socially quite skilled, and it is often not immediately apparent how disabled she is to the observer. Her eldest two children were sporadically attending my clinic when she discovered she was pregnant. Her husband is employed as a fast food worker, and they have no insurance. "Sue" has a history of premature deliveries in the past, and at the time of her last delivery, didn't tell anybody she was having contractions (although she was on the ward; hospitalized for preeclampsia!) until delivery was imminent. A truly Herculean effort was undertaken by the clerical staff to ensure that if she appeared in clinic, she would be seen even if she was confused about why she was there. Her pregnancy was stormy, complicated by premature labor, poor weight gain, and infection. However, she did make it to term and delivered her baby. The Department of Children and Family Services has also been involved in providing ongoing home support.

"Beth" is a 27 year old woman who travels one hour on public transportation to receive free care at my clinic. She works full time as a waitress, and has no medical insurance and does not qualify for public aid. She worked up until the day of her delivery, at which time she took two buses and a subway while in labor to Cook County Hospital. During her pregnancy she had a difficult time with her employer as he objected to the amount of time she needed to spend coming to and waiting in my clinic, which frequently resulted in missed appointments. Four weeks after the delivery of her infant she was working again full time to support her young son, for whom she has many aspirations.

Thank you for your attention to my testimony. I am just one physician in a huge system. There are thousands of stories. The need is great, and the resources are sparse. Let us work together to improve life at its start for all our citizens.

Chairman **Miller**. Thank you. Dr. Weigel.

STATEMENT OF WILLIAM J. WEIGEL, M.D., OBSTETRICIAN, AURORA, IL

Dr. **Weigel**. My name is Dr. Weigel. I am an obstetrician, and thank you for asking me here.

I am a country doctor, basically. I am not from Chicago, although I was raised in the suburbs of Chicago. I practiced in the town of Aurora, about 40 miles west of here, for the past 37 years.

I am concerned—I am a Board-Certified Obstetrician, and I am concerned about the general mortality, both in the State and my county, which happens to be the second highest, outside of Cook County and Chicago. I am concerned because our patients are underserved. We do have a prenatal clinic, run by the visiting nurses, run by an adequate well-trained doctor who, however, has been so busy she can no longer do it.

I think you have to realize when we talk about the malpractice crisis that there is a crisis. And this is one of the reasons that most obstetricians refuse, or will not care for public aid people that are uninsured.

When I opened my office in 1950, my malpractice insurance was $35 a year. In 1971, Medicaid paid about $225 for a normal delivery. My malpractice insurance then was $4,000 a year. If I were practicing now, and I am retired, it would cost me $45,000 a year to have the minimum for staff appointment, because most hospitals demand staff appointment, adequate malpractice insurance as a part of the staff.

Most obstetricians will, to further protect themselves, take $3 million to $6 million, at a cost of over $100,000 a year. Most obstetricians tell me that the state reimburses them around $300. I was happy to hear that it is $450. That kind of cuts it down, because in order for him to collect this and pay the minimum malpractice insurance, he would have to deliver 100 Medicaid patients per year. And as you can see very readily, that that does not—there is no take-home pay or office expense.

However, every problem has a solution. And we, at least, in the hinterlands have decided that we are concerned. The obstetricians in my area are concerned about it and they have decided to do something about it. Through the efforts of the Illinois Public Health and our Health Department, we were able to get a grant of $265,000, from the State, to be matched by the County, for prenatal care from private physicians. What we are doing in the County is we are given an additional monetary award as a bonus to cover just the costs of what malpractice would cost them, and it is officially called their Participating Achievement Award. Our obstetricians are running the program through the local medical society. They are enthused about the program. Twenty-nine of them already signed up. We only had about 33 or 34 in the whole county. General practitioners in my area, family physicians will not deliver babies because their malpractice insurance is so high, just to do obstetric services it is not worth it to them, plus all the stress.

These patients will be seen by the private obstetrician in his office. They will no longer be treated as second-class citizens. Every woman is entitled to adequate prenatal care. Every woman is entitled to have a good, normal baby. And unless they get adequate prenatal care, which is the most important part of obstetrics, they are going to have these babies who are underweight, and who may have difficulties, and may have to be transferred to intensive care centers.

I am aware of the costs. My grandson, two years ago, was born with several defects, which fortunately were correctable, and I am indeed in gratitude to Children's Memorial. He has had six operations here, and they have done a wonderful job. But I know what the cost would have been if they did not have insurance. Somewhere around $100,000. And this is what we are talking about.

The most important facet of our program is that it is being run locally by the local health department through a medical society for the local obstetricians. These patients are going to be treated as private patients. And they are not going to have to wait three or four weeks before seeing a doctor. Nor are they going to have to worry about having to go to some high risk clinic, because they are going to be taken care of just as well as a patient who has insurance and is paying the bill right.

If you realize that because of the amount put out for malpractice, the patients have been subsidizing—the private patient is subsidizing the Medicaid patients in the doctor's office. And it is not fair, because they are also taxpayers.

You know, we, as a Country, subsidize the tobacco farmers for billions of dollars on a product that causes thousands of deaths a year, and God knows how many billions of dollars in health care services, and we do not bother to subsidize a program that saves lives.

At least we feel in our county the underserved are going to have a decent chance to get good prenatal care. We will know and we will be able to keep statistics within the next year or two to see how the program works.

We have to be very careful because it is going to be through the County. It is going to cost our taxpayers in the County, and it was the matching funds was overwhelming the County a bit. It is going to cost the taxpayers whose house is valued at $50,000 exactly the cost of 2 packs of cigarettes a day, and if it is in 6 figures, it may cost them the cost of five packs of cigarettes a day. I think that is awful cheap to save a life. What do you put value on one human life?

I am not involved in the program. I am retired. I have never been sued for malpractice, because I thought I gave my patients adequate medical care. And I think the fact that I was never sued proved it. I took time, And as long as a private physician takes time, he doesn't have to worry about malpractice.

I am glad that somebody cares to help these underserved, and I am very pleased and proud that I lived long enough to see my area do something about a problem without having to go and ask for a handout from the Federal Government, without having all the regulations put out by the Federal Government, the regulations put out by the state, and do it locally, by local people, who know the problem, and are concerned and moved to do something about it. Thank you.

[Prepared statement of William J. Weigel, M.D., follows:]

Prepared Statement of William J. Weigel, M.D., Obstetrician, Aurora, IL

MY NAME IS WILLIAM J. WEIGEL M.D.. I AM A LICENSED PHYSICIAN IN THE STATE OF ILLINOIS. I GRADUATED FROM LOYOLA UNIVERSITY SCHOOL OF MEDICINE IN APRIL 1943. I SERVED IN THE ARMY OF THE UNITED STATES IN WORLD WAR II FROM JANUARY 1944 TO AUGUST 1946, SERVING OVERSEAS IN THE EUROPEAN THEATER OF OPERATIONS. I BEGAN MY POST GRADUATE TRAINING IN OCTOBER 1946 IN OBSTETRICS AND GYNECOLOGY UNDER THE LOYOLA UNIVERSITY CLINICS AND SERVED AT ST. ANNE'S HOSPITAL, LEWIS MEMORIAL HOSPITAL AND MERCY HOSPITRAL IN CHICAGO. I FINISHED MY GRADUATE TRAINING ON DECEMBER 31, 1949 AND BEGAN MY PRACTICE OF OBSTETRICS AND GYNECOLOGY IN AURORA, ILLINOIS ON FEBRUARY 1, 1950. I WAS CERTIFIED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY IN MAY 1953. I RETIRED FROM ACTIVE PRACTICE ON DECEMBER 31, 1986. I AM CONCERNED ABOUT THE INFANT MORTALITY AND MORBIDITY IN MY COUNTY AND MY STATE. ILLINOIS, IS 46TH OUT OF 50 IN INFANT MORTALITY AND MY COUNTY, KANE, HAS THE SECOND HIGHEST INFANT MORTALITY, ONLY EXCEEDED BY COOK COUNTY INCLUDING CHICAGO.

IN MY TRAINING AND IN MY EXPERIENCE, THE MOST IMPORTANT PART OF OBSTETRICS IS PRENATAL CARE. IT IS MY EXPERT OPINION THAT THE

REASON FOR SUCH A HIGH INFANT MORTALITY IS DUE TO LACK OF PRENATAL CARE FOR THE UNDERSERVED. THE UNDERSERVED INCLUDE THE MINORITIES AND THE ADOLESCENT. BOTH GROUPS HAVE THE HIGHEST INFANT MORTALITY BECAUSE OF INADEQUATE PRENATAL CARE. THE UNDERSERVED CANNOT AFFORD PRIVATE CARE. THEY HAVE TO ATTEND PRENATAL CLINICS SERVED BY THE BOARDS OF HEALTH OR IN THE CASE IN OUR COUNTY, BY THE VISITING NURSES ASSOCIATION. THE COMPETENCE OF THE PHYSICIANS IN SUCH CLINICS IS QUESTIONABLE. THERE IS NO PERSONAL DOCTOR-PATIENT RELATIONSHIP IN THIS TYPE OF CARE. IN THIS SITUATION, WHO IS A PREGNANT WOMAN TO CALL IF SHE STARTS TO EXHIBIT POSSIBLE COMPLICATION AT ANY TIME DURING HER PREGNANCY. SHE USUALLY ENDS UP IN THE EMERGENCY ROOM OF THE HOSPITAL AND BY THAT TIME IT IS TOO LATE FOR ANY PREVENTATIVE MEASURES. THE RESULTS ARE PREMATURE, UNDERWEIGHT INFANTS, WHO MAY SURVIVE FOR A WHILE IN A AN INFANT CRITICAL CARE UNIT BUT MAY DIE EVEN WITH ALL OF THE MODERN INTENSIVE CARE MEASURES THAT ARE TAKEN. IF THE INFANT SURVIVES, THE COST OF SUCH HOSPITALIZATION IS ENORMOUS. THIS I CAN ATTEST TO PERSONALLY AS ONE OF MY GRANDCHILDREN WAS BORN WITH CORRECTABLE DEFECTS AND HAS GONE THROUGH SIX HOSPITALIZATIONS FOR THEIR CORRECTION.

THE ADOLESCENTS HAVE ADDED PROBLEMS AND ALSO HAVE THE HIGHEST NUMBER OF COMPLICATIONS AND INFANT MORTALITY. MANY OF THESE INDIVIDUALS DO NOT HAVE PRIVATE PHYSICIANS BECAUSE THEY ARE TOO OLD FOR THE PEDIATRICIAN AND ARE NOT OLD ENOUGH TO HAVE FOUND A PRIVATE PHYSICIAN. MANY OF THEM CANNOT AFFORD MEDICAL CARE BECAUSE THEY ARE NOT COVERED BY INSURANCE AND MAY NOT EVEN HAVE PUBLIC AID. MANY PRESENT THEMSELVES IN THE EMERGENCY ROOM FOR

THEIR FIRST PRENATAL VISIT AND BY THIS TIME ARE HAVING PROBLEMS. THE PHYSICIANS WHO RENDER CARE ARE ARE UNDER A DISTINCT DISADVANTAGE BECAUSE THEY KNOW NOTHING OF THEIR PAST HISTORY OR THEIR PRENATAL COURSE. IF THE INFANT IS IN TROUBLE, IT IS SENT TO THE INTENSIVE CARE NEONATAL CENTER AT GREAT EXPENSE TO THE TAXPAYERS.

YOU MAY LIKE TO CONCLUDE THAT THESE UNDERSERVED INDIVIDUALS ARE GETTING PRENATAL CARE AT THE VARIOUS CLINICS AROUND THE STATE. AT THE MOST THESE CLINICS ARE STOP-GAP MEASURES BROUGHT ABOUT BY CRISIS. MUST WE ALWAYS HAVE A CRISIS TO ACT? ARE THESE UNDERSERVED INDIVIDUALS SECOND CLASS CITIZENS OR DO THEY DESERVE THE BEST CARE THAT MODERN MEDICINE CAN GIVE THEM.

IN ADDITION, WHEN THE PREGNANT WOMEN REGISTERED IN ONE OF THESE CLINICS, GOES INTO LABOR SHE GOES TO THE HOSPITAL AND GETS WHOEVER IS ON CALL TO TAKE CARE OF HER. YOU MAY SAY "WHAT'S WRONG WITH THAT?" ALL I ASK IS THAT YOU PUT YOURSELF IN THEIR SITUATION? HOW WOULD YOU FEEL IF YOU WERE GOING TO A CLINIC FOR CARE, NOT SEEING THE SAME DOCTOR NECESSARILY ON EACH VISIT, AND WHEN A CRISIS AROSE, YOU WENT TO THE HOSPITAL, AND GOT THE PHYSICIAN WHO WAS ON CALL, NOT KNOWING HIS QUALIFICATION, HIS REPUTATION, OR EVEN HIS NAME.

WHAT THEN IS THE REASON THESE UNDERSERVED INDIVIDUALS CANNOT GET PRIVATE CARE EVEN IF THEY ARE ON PUBLIC AID. THE ANSWER IN THIS STATE IS SIMPLE. IT IS THE MALPRACTICE CRISIS. WHEN I OPENED MY PRACTICE IN 1950, MY MALPRACTICE INSURANCE WAS THIRTY-FIVE DOLLARS A YEAR. BECAUSE OF THE EXORBITANT AWARDS THAT ARE PREVALENT TODAY, HOSPITALS DEMAND THAT THE PHYSICIANS CARRY ADEQUATE MALPRACTICE INSURANCE AS ONE OF THE REQUIREMENTS FOR STAFF APPOINTMENT. THE MINIMUM AMOUNT THEY DEMAND IN THIS AREA

IS A MILLION DOLLARS AN INCIDENT AND THREE MILLION TOTAL. IF I WERE IN PRACTICE TODAY, THIS WOULD COST ME FORTY-FIVE THOUSAND DOLLARS A YEAR. IN OUR NEIGHBORING STATE OF INDIANA THE COST WOULD BE A LITTLE OVER A THIRD OF THAT AMOUNT. MOST PHYSICIANS TO BETTER PROTECT THEMSELVES AND THEIR FAMILIES CARRY THREE MILLION AN INCIDENT AND THIS COSTS WELL OVER A HUNDRED THOUSAND DOLLARS A YEAR. THE STATE OF ILLINOIS ALLOWS THE PHYSICIAN THE SUM OF $300.00 FOR A NORMAL DELIVERY. IT IS SIMPLE ARITHMETIC TO DETERMINE THAT AN OBSTETRICIAN WOULD HAVE TO DELIVER 150 PUBLIC AID PATIENTS JUST TO PAY FOR HIS MINIMUM MALPRACTICE INSURANCE COVERAGE. THE PHYSICIANS PRIVATE PATIENTS, WHO ARE ALSO TAXPAYERS, ARE SUBSIDIZING THE COST OF THE TREATMENT FOR THE UNDERSERVED. THIS IS AN ADDED BURDEN TO THE PRIVATE PATIENTS AND AS A RESULT THE COST FOR PRIVATE HEALTH INSURANCE HAS SKYROCKETED IN THE PAST YEARS. EVERYBODY EXPECTS THEIR BABY TO BE NORMAL AND WHEN A COMPLICATION ARISES OR A DEFECT IS NOTED THEY ARE QUICK TO SUE. IN OUR AREA, THERE HAVE BEEN MANY MALPRACTICE SUITS AGAINST OUR OBSTETRICIANS EVEN THOUGH THE INDIVIDUAL WAS TAKEN CARE OF BY A PRENATAL CLINIC AND THE OBSTETRICIAN FIRST SAW THE PATIENT WHEN SHE WENT INTO LABOR! PEOPLE ARE QUICK TO BLAME THE PHYSICIANS FOR THIS CRISIS BUT WHAT WOULD YOU DO IF YOU WERE IN THE SAME SITUATION? I HOPE NOW, AT LEAST, YOU UNDERSTAND WHY PHYSICIANS REFUSE TO CARE FOR THE UNDERSERVED.

TO EVERY PROBLEM, THERE HAS TO BE A SOLUTION. THE OBSTETRICIANS ARE JUST AS CONCERNED AS ANYBODY ABOUT THE INFANT MORTALITY, AND AT LEAST THE OBSTETRICIANS IN KANE COUNTY ARE GOING TO DO SOMETHING ABOUT IT. RECENTLY THE STATE HEALTH DEPARTMENT GAVE A GRANT TO OUR COUNTY HEALTH DEPARTMENT TO SET UP A PRIVATE CARE

PRENATAL PROGRAM FOR OUR UNDERSERVED. THE COUNTY BOARD HAD TO MATCH THESE FUNDS WHICH THEY DID BY AN OVERWHELMING VOTE. OUR HEALTH DEPARTMENT HAS AN AGREEMENT WITH OUR KANE COUNTY MEDICAL SOCIETY TO PROVIDE PRENATAL CARE BY PRIVATE PHYSICIANS FOR THE UNDERSERVED. THOSE PATIENTS ON PUBLIC AID OR WITHOUT FUNDS WILL BE TAKEN CARE OF BY THE PRIVATE OBSTETRICIANS IN THEIR OFFICE. THESE PRIVATE OBSTETRICIANS WILL BE REIMBURSED ONLY ENOUGH TO COVER THE COST OF THEIR MALPRACTICE PREMIUM, NOT TO COVER ANY OFFICE EXPENSE OR TAKE HOME PAY. OUR OBSTETRICIANS ARE ENTHUSIASTIC ABOUT OUR PROGRAM AND ARE SETTING UP IMPLEMENTATION OF IT AND IT WILL BE STARTED WITHIN A VERY SHORT TIME. IT IS AN INNOVATIVE PROGRAM, THE FIRST OF ITS KIND IN THE STATE, AND POSSIBLY IN THE COUNTRY. WHAT IS THE COST TO THE AVERAGE TAXPAYER IN OUR COUNTY? TO THE AVERAGE TAXPAYER THE COST WILL BE THE PRICE OF TWO PACKS OF CIGARETTES A YEAR AND THOSE WHOSE REAL ESTATE IS IN THE SIX FIGURES, THE COST WOULD BE THE PRICE OF FIVE PACKS OF CIGARETTES A YEAR. WHAT A PRICE TO PAY FOR SAVING A LIFE!!!! THE MOST IMPORTANT FACET OF THIS PROGRAM IS THAT IT IS HAS BEEN DEVELOPED AND IMPLEMENTED BY THE LOCAL MEDICAL SOCIETY, WITH LOCAL WELL TRAINED-OBSTETRICIANS INVOLVED, WITHOUT ALL OF THE BUREAUCRATIC REGULATIONS DICTATED BY THE FEDERAL OR STATE GOVERNMENTS AND OVERSEEN BY OUR LOCAL COUNTY HEALTH DEPARTMENT. THE PROGRAM HAS HAD THE USUAL NUMBER OF CRITICS FROM WELL-INTENTIONED BUT UNIFORMED INDIVIDUALS. I AM TIRED OF HEARING THE OLD TIME-WORN ARGUMENTS THAT THIS PROGRAM WILL GIVE RISE TO THESE PATIENTS HAVING MORE BABIES. I HAVE HEARD THIS FOR THE PAST FORTY-FOUR YEARS ON EVERY PROGRAM THAT HAS BEEN PROPOSED. ON THE CONTRARY, THIS PROGRAM MAY WELL SOLVE A GOOD DEAL OF THE PROBLEM.

WITH THIS PROGRAM. THESE PATIENTS WILL NOW HAVE A PRIVATE PHYSICIAN AND WILL NOW BE ABLE TO GET BIRTH CONTROL ADVICE THAT IS NECESSARY FOR THEIR PHYSICAL CONDITION AND ACCORDING TO THEIR RELIGIOUS BELIEFS. SOME CRITICS SAY WE ARE SUBSIDIZING THE THE COST OF PATIENT CARE. THAT IS ONE CRITICISM I WILL ADMIT.

THIS COUNTRY SUBSIDIZES THE TOBACCO FARMER TO THE TUNE OF BILLIONS OF DOLLARS TO PRODUCE A PRODUCT THAT CAUSES THOUSANDS OF DEATH A YEAR AND BILLIONS OF DOLLARS FOR HEALTH CARE SERVICES.

IS IT MORALLY WRONG TO SUBSIDIZE A PROGRAM TO SAVE A LIFE?

I AM NOT ADVOCATING THAT THIS PROGRAM BE DONE BY ANY GOVERNMENT, FEDERAL OR STATE. IT SHOULD BE DONE ON A LOCAL LEVEL BY THE LOCAL COUNTY HEALTH DEPARTMENT, THE LOCAL MEDICAL SOCIETY, AND BY THE LOCAL OBSTETRICIANS WHO KNOW THE LOCAL PROBLEMS.

THIS PROGRAM MAY OR MAY NOT BE THE ANSWER BUT AT LEAST IT IS A STEP IN THE RIGHT DIRECTION TO PROVIDE ADEQUATE PRENATAL CARE TO THE UNDERSERVED. RESULTS WILL TAKE TIME TO EVALUATE, BUT IN MY HEART I FEEL THAT AT LEAST IN OUR COUNTY, WE WILL BRING OUR INFANT MORTALITY DOWN TO THE ACCEPTED LEVEL THROUGHOUT OUR COUNTRY. LET ME CONCLUDE BY SAYING THAT SINCE I AM RETIRED, I HAVE NO FINANCIAL INTEREST IN THE PROGRAM BUT I AM GLAD THAT I HAVE LIVED LONG ENOUGH TO SEE POSITIVE ACTION TAKEN ON A VERY SERIOUS PROBLEM. I KNOW IT WILL BE SUCCESSFUL FOR JUST ONE REASON- BECAUSE SOMEBODY CARED.

Chairman MILLER. Thank you. Mr. Perkins.

STATEMENT OF USENI EUGENE PERKINS, SOCIAL SERVICES DIRECTOR, CHICAGO URBAN LEAGUE, CHICAGO, IL

Mr. PERKINS. My name is Useni Eugene Perkins, Director of Social Services at Chicago Urban League. On behalf of President James W. Compton and the Chicago Urban League, I would like to express our gratitude to Congressman George Miller and the House Select Committee on Children, Youth, and Families for the critical and timely subject of infant mortality. I have already submitted a statement and I will just elaborate on a few highlights of that statement.

The problem of infant mortality cannot be fully remediated unless we view it as one of the main barometers for measuring and assessing the quality of life in a given community. Because the fact is that in fact, infant mortality crosses every facet of health and socioeconomic concerns, it is imperative that this is done. If we are to have healthy babies, we must have healthy communities. If we are to have healthy mothers before and after they give birth, we must have healthy communities. And if we are to have healthy communities, we must drastically increase employment, improve a deteriorating public school system, provide more decent and affordable housing, and assure that all mothers and their newborns receive optimal medical care.

During its one and a half years as the CNCE for the largest infant mortality network in Illinois, the Chicago Urban League has learned that unless we address these issues, the problem with infant mortality will be with us well into the 2lst Century and beyond.

It is fatuous for us to feel that we will significantly reduce infant mortality unless we significantly reduce the poverty and oppression that contributes to it. And it will be irresponsible on our part as a Nation to claim to respect the dignity and rights of our people not to implore its vast resources to deal with this disgraceful problem. It is inexcusable for a nation with the wealth that America possesses to have such a high rate of infant mortality. While Black babies are dying at a rate higher than in most other industrial nations, America seems more occupied with exploring the universe than adding to its vast stockpile of omminence.

Of course, we believe that it is important to protect our Nation from those unfriendly nations that threaten our national security. But we also feel that we must protect our newborn, our children, and our youth from the ravishes of poverty. There is an ancient African proverb that states children are the reward of life. Implicit in this proverb is that our children should be cherished, protected and respected. I am not so naive to believe that democracy or any other form of government can totally alleviate poverty. We do not live in a Camelot world, and the welfare of our young is not a value held by all people. Nonetheless, it is not a romantic notion to believe that most of us do have a high regard for human life.

Those who hold this belief understand that caring for children is like caring for a harvest that is yet to be reaped. They also know that a contaminated harvest can only yield contaminated crops.

And from that—and the contaminated crops will not provide the nourishment they need to survive and prosper.

If we are truly serious about reducing infant mortality, in this nation, we must reduce the contamination that contributes to this national crisis. Thank you.

[Prepared statement of Useni Eugene Perkins follows:]

PREPARED STATEMENT OF USENI EUGENE PERKINS, SOCIAL SERVICES DIRECTOR, CHICAGO URBAN LEAGUE, CHICAGO, IL

THE CHICAGO URBAN LEAGUE WAS FOUNDED IN 1916 AND IS CHICAGO'S OLDEST AND LARGEST FULL-TIME RACE RELATIONS AGENCY. THE LEAGUE'S MISSION IS TO ELIMINATE RACIAL DISCRIMINATION AND SEGREGATION AND TO WORK FOR THE ACHIEVEMENT OF EQUAL OPPORTUNITY AND PARITY FOR BLACKS AND OTHER MINORITIES IN EVERY FACET OF AMERICAN LIFE.

OUR PROGRAMMATIC INITIATIVES IN THE AREA OF HEALTH HAVE BEEN CONSISTENT WITH OUR SEVENTY-ONE (71) YEAR OLD MISSION AND PURPOSE FOR GOOD HEALTH IS ESSENTIAL TO THE ENJOYMENT OF ALL OTHER BASIC RIGHTS IN SOCIETY. THROUGHOUT THE YEARS, THE CUL HAS MAINTAINED A LEADERSHIP ROLE IN MANY HEALTH ISSUES THAT PARTICULARLY IMPACT THE BLACK COMMUNITY. FOR EXAMPLE, IN 1976, THE CUL ESTABLISHED THE CUL SICKLE CELL PROJECT AS A COOPERATIVE SICKLE CELL CENTER.

THE PROJECT PLAYED A MAJOR ROLE IN EDUCATING PEOPLE ABOUT THIS DISEASE, AND PROVIDED DIRECT ASSISTANCE TO HUNDREDS WHO WERE STRICKEN WITH THE SICKLE CELL TRAIT. MORE RECENTLY, THE CUL WAS INVOLVED IN THE SCREENING OF HYPERTENSION AMONG BLACKS WITH THE AMERICAN RED CROSS.

IN 1986 THE LEAGUE ASSUMED THE ROLE OF A COMMUNITY NETWORK COORDINATING ENTITY (CNCE) FOR THE ILLINOIS INFANT MORTALITY REDUCTION INITIATIVE (IMRI). AS A CNCE, WE SERVICE THE LARGEST NETWORK IN THE STATE OF ILLINOIS WHICH CONSISTS OF FIVE (5) COMMUNITIES: OAKLAND, DOUGLAS, WASHINGTON PARK, GRAND BOULEVARD AND FULLER PARK. THESE COMMUNITIES ARE AMONG THE MOST IMPOVERISHED IN CHICAGO AND THEY ALL RANK HIGH IN INFANT MORTALITY. FOR EXAMPLE, IN 1985, GRAND BOULEVARD RECORDED THIRTY-TWO (32) CASES OF INFANT MORTALITY OUT OF 1,103 RECORDED BIRTHS GIVING IT AN INFANT MORTALITY RATE OF 29.0 PER THOUSAND, WELL OVER THE 12 PER THOUSAND THE STATE HOPES TO ACHIEVE BY 1990. THESE ALARMING STATISTICS SIMILARLY REFLECT THE CONDITION OF THE OTHER FOUR (4) COMMUNITIES THAT COMPRISE THE SOUTH SIDE FAMILY HEALTH NETWORK (SFHN) SERVED BY THE CUL. THE PRIMARY RESPONSIBILITIES OF THE CUL IN ITS ROLE AS CNCE FOR THESE COMMUNITIES ARE: (1) FISCAL MANAGEMENT OF THE ILLINOIS DEPARTMENT OF HEALTH (IDOH) FUNDS, (2) PROGRAM MONITORING AND AUDITING OF ALL SERVICES RENDERED BY THE NETWORK AND (3) TO ENSURE THAT THE OBJECTIVES OF THE IMRI, NOW KNOWN AS FAMILIES WITH A FUTURE (FWF), ARE MET.

IN CARRYING OUT THESE RESPONSIBILITIES, IT HAS BECOME CLEAR TO THE CUL THAT THE PROBLEM OF INFANT MORTALITY IS BROAD IN SCOPE AND TOUCHES NEARLY EVERY FACET OF AMERICAN LIFE. ONCE PERCEIVED AS ESSENTIALLY A MEDICAL PROBLEM, INFANT MORTALITY MUST NOW BE VIEWED AS ONE OF THE MOST TELLING INDICES OF THE QUALITY OF LIFE IN A GIVEN COMMUNITY. THIS IS TO SUGGEST THAT THE SYSTEMIC CAUSES OF INFANT MORTALITY WILL NOT BE ADDRESSED IF MERELY GEARED TO THE REMEDIATION OF HEALTH DEFICIENCIES, BUT MUST ALSO DIRECTLY ADDRESS SOCIO-ECONOMIC CONDITIONS AS WELL. WHEN THE QUALITY OF LIFE IN A GIVEN COMMUNITY IS INUNDATED WITH HIGH UNEMPLOYMENT, POOR SANITARY CONDITIONS, SLUM HOUSING AND A LONG HISTORY OF SOCIAL AND ECONOMIC NEGLECT, ONE CAN EASILY PREDICT A HIGH RATE OF INFANT MORTALITY. THUS, IT IS NO STARTLING REVELATION THAT BLACK COMMUNITIES CONTINUE TO HAVE THE HIGHEST RATES OF INFANT MORTALITY.

ALTHOUGH WE HAVE THE MEDICAL TECHNOLOGY TO ENSURE THAT EVEN THE POOREST OF WOMEN GIVE BIRTH TO HEALTHY BABIES, THIS TECHNOLOGY HAS NOT ALWAYS BEEN MADE ACCESSIBLE TO THEM. AND TO COMPOUND THIS PROBLEM, WE HAVE YET TO PROVIDE ALL COMMUNITIES WITH THE SOCIAL AND ECONOMIC RESOURCES NEEDED TO IMPROVE THE QUALITY OF LIFE FOR ALL RESIDENTS. CONSEQUENTLY, EVEN IF A HIGH RISK MOTHER AND HER NEWBORN CHILD ARE FORTUNATE TO HAVE ACCESS TO DESIRABLE MEDICAL RESOURCES, IF SHE AND HER CHILD ARE TO RETURN TO AN IMPOVERISHED COMMUNITY -- BOTH MOTHER AND BABY WILL, MOST LIKELY, CONTINUE TO BE AT HIGH RISK. THIS IS NOT ONLY APPALLING, BUT A GRAPHIC INDICATION OF THE LOW VALUE AMERICA PLACES ON THE LIVES OF BLACK AND POOR PEOPLE.

OBVIOUSLY, THIS TRAVESTY MUST BE REVERSED IF AMERICA IS TO IMPROVE ITS PATHETICLY LOW RANKING AMONG THE TWENTY (20) DEVELOPED NATIONS. A RECENT REPORT BY THE CHICAGO SUN-TIMES INDICATED THAT AMERICA'S INFANT MORTALITY RATE PER 1,000 LIVE BIRTHS WAS HIGHEST OF THIS GROUP.

THE PROBLEM OF INFANT MORTALITY IS ONE WHICH CHALLENGES OUR NATIONAL, STATE AND LOCAL GOVERNMENTS TO RESTRUCTURE THEIR PRIORITIES SO THAT HUMAN LIFE IS PLACED AT THE TOP OF THE AGENDA, AND ADEQUATE RESOURCES COMMITTED TO PROGRAMS THAT ENHANCE ITS QUALITY. ON THIS BASIS THE CUL OFFERS THE FOLLOWING RECOMMENDATIONS TO THIS COMMITTEE:

1) THE CRISIS OF INFANT MORTALITY SHOULD BE VIEWED IN THE NATURE OF A "STATE OF EMERGENCY" REQUIRING COMPREHENSIVE AND COORDINATED PROGRAMS AND SERVICES IN ADDRESSING THE PROBLEM. ALTHOUGH THE STATE OF ILLINOIS SHOULD BE COMMENDED FOR PROVIDING FUNDS TO REDUCE INFANT MORTALITY, WE BELIEVE THAT THE PRESENT LEVEL OF FUNDING IS FAR FROM BEING SUFFICIENT TO HAVE A SIGNIFICANT AND LASTING IMPACT ON THE PROBLEM. THEREFORE, ADDITIONAL FUNDING TO THE STATE FROM THE FEDERAL LEVEL SHOULD BE MADE AVAILABLE TO FUND A MUCH MORE COMPREHENSIVE PROGRAM TO REDUCE INFANT MORTALITY.

2) THAT THERE BE GREATER COORDINATION AND COOPERATION AMONG THE MAJOR STATE, FEDERAL AND LOCAL AGENCIES IF WE ARE TO HAVE A VIABLE NETWORK THAT TOUCHES ALL FACETS OF THE INFANT MORTALITY PROBLEM. IF LOCAL COMMUNITY NETWORKS ARE TO BE SUCCESSFUL, THESE AGENCIES MUST BE TOTALLY COMMITTED AND SUPPORTIVE OF THE [illegible] INITIATIVE.

3) THAT PERINATAL CENTERS BECOME MORE DIRECTLY INVOLVED IN THE FUNCTIONS OF COMMUNITY NETWORKS TO ENSURE THAT ALL HIGH RISK MOTHERS AND THEIR CHILDREN RECEIVE OPTIMUM MEDICAL CARE.

4) THAT THE CHICAGO DEPARTMENT OF HEALTH (CDOH) INCREASE ITS HOME VISITING NURSING STAFF TO BE MORE REPRESENTED OF THE HEALTH NEEDS POSED BY HIGH RISK MOTHERS AND THEIR BABIES. ALSO, TO FACILITATE THIS INCREASE, THE CDOH MUST SHORTEN THE EXCESSIVE LENGTH OF TIME IT TAKES TO HIRE ESSENTIAL PERSONNEL SUCH AS REGISTERED NURSES.

5) THAT AFFORDABLE AND HIGHER QUALITY HOUSING BE MADE AVAILABLE TO THE INDIGENT, AND THERE BE GREATER ENFORCEMENT OF ALL BUILDING CODE VIOLATIONS. IN ADDITION, WE NEED TO CREATE MORE LONG-TERM AND SHORT-TERM RESIDENTIAL FACILITIES FOR HIGH RISK MOTHERS AND THEIR BABIES.

6) THAT THE WIC PROGRAM BE MAINTAINED AND EXPANDED TO ENSURE ALL HIGH RISK MOTHERS AND THEIR BABIES RECEIVE PROPER NUTRITION COUNSELING AND FOOD PROVISION.

7) THAT A MORE PRECISE AND COMPREHENSIVE HEALTH EDUCATION PROGRAM BE ESTABLISHED AND IMPLEMENTED BY THE PUBLIC SCHOOLS TO ENSURE ALL STUDENTS RECEIVE UP-TO-DATE INFORMATION REGARDING ALL HEALTH ISSUES.

8) TO ESTABLISH A COMPREHENSIVE CASE MANAGEMENT SYSTEM THAT IDENTIFIES AND TRACKS EVERY HIGH RISK MOTHER AND BABY AFTER THEY LEAVE THE HOSPITAL TO ENSURE THEY RECEIVE OPTIMUM MEDICAL CARE FOR A MINIMUM PERIOD OF THREE (3) YEARS.

9) THAT THE FEDERAL BUDGET BE REPRIORITIZED TO REFLECT AND ACCOMMODATE THE HEALTH, ECONOMIC AND SOCIAL NEEDS OF A HIGH RISK POPULATION THAT IS DISPROPORTIONATELY REPRESENTED BY BLACKS AND OTHER MINORITIES.

10) THAT H.R. 1398, "THE QUALITY OF LIFE ACTION ACT" BE ENACTED, IN FULL, TO ENSURE THAT ALL PEOPLE HAVE ACCESS TO FULL EMPLOYMENT.

IT IS INEXCUSABLE FOR A NATION WITH THE WEALTH AND RESOURCES THAT AMERICA POSSESSES TO HAVE SUCH AN ALARMING AND DEPLORABLE RATE OF INFANT DEATHS. WHILE BABIES ARE DYING AT A RATE HIGHER THAN IN OTHER LARGE INDUSTRIALLY DEVELOPED NATIONS, AMERICA'S MILITARY BUDGET AND SPENDING ON ARMAMENTS CONTINUE TO STAGGER THE IMAGINATION.

AS A CAPITALIST NATION, AMERICA IS OBSESSED WITH THE BOTTOM LINE THIS TERM IS NOT ONLY IDENTIFIED WITH ITS BUSINESS COMMUNITY BUT IN RECENT YEARS HAS ALSO BEEN ASSOCIATED WITH THE OUTCOMES OF OUR HEALTH AND SOCIAL SERVICE PROGRAMS. WHEN A BUSINESS'S BOTTOM LINE IS IN THE BLACK IT IS CONSIDERED TO BE SUCCESSFUL.

HOWEVER, IF WE EXPECT OUR HEALTH AND SOCIAL SERVICE PROGRAMS TO ACHIEVE A FAVORABLE BALANCE SHEET, WE MUST PROVIDE THEM WITH SUFFICIENT FEDERAL FUNDS AND RESOURCES TO ENSURE THAT ALL CITIZENS ENJOY A DECENT AND ACCEPTABLE STANDARD OF LIVING.

THE CUL STRONGLY AND PASSIONATELY URGES THIS COMMITEE TO EXERT WHAT POWER AND INFLUENCE IT HAS TO ENSURE THAT WE HAVE A COMPREHENSIVE, WELL-COORDINATED INFANT MORTALITY PROGRAM WHICH ADDRESSES ITSELF TO SAVING THE LIVES OF TODAY'S BABIES AND THOSE OF GENERATIONS YET NOT BORN.

Chairman **Miller**. Thank you. Ms. Velasquez.

STATEMENT OF CARMEN VELASQUEZ, BOARD MEMBER, PROJECT ALIVIO, CHICAGO, IL

Ms. **Velasquez**. My name is Carmen Velasquez. I am a board member of Project Alivio. I appreciate the audience, and the Select Committee of Children, Youth and families for allowing us to testify. My testimony will be on health issues in three predominantly Hispanic communities, Pilsen, Little Village, and Back of the Yards. And I am going to ask the indulgence because I will have to read this and I do not want to summarize because there are some data here that we took trouble to put together, and both you and the audience should hear it.

Research projects that if the current rate of population growth continues, Hispanics will constitute by the year 2000, 24 percent of the City's population.

In the 1980 Census, Hispanics already accounted for 21 percent of the population under 15 and 24 percent of the population under five.

Pilsen, Little Village and Back of the Yards, three predominantly Mexican communities in Chicago, comprise 25 percent of the total Hispanic population in the city. The following statistics which directly relate to the communities are documented by South Lawndale/Pilsen Comprehensive Health Network.

LIVE BIRTHS

The birth rates per 1,000 for South Lawndale and Pilsen rank first and second, respectively, among the 77 community areas in the entire City of Chicago come from these two community areas. Statistically these areas are among the two to three youngest areas of the city, so we can assume the high fertility rates will continue. It is essential that we begin to deal with these high rates and future prevention of morbidity and mortality of infants in the community.

MOTHERS UNDER 20

In absolute numbers the two communities rank eleventh and eighteenth, respectively in births to mothers under the age of 20 years old. This is another reflection of the youth of the community which does not show signs of aging at this point.

MEDICAL INDIGENCY

The Latino Institute survey indicates the rate of medical indigency to be greater than 30 percent in the Pilsen-Little Village area. This was based on a phone survey in 1985. When the population who do not have phones is taken into account, this rate will rise closer to 35 to 40 percent. In a face to face survey of 308 households done by the Latino Institute in the summer of 1987, 44.6 percent of 1,400 plus persons were without medical insurance. This is reflected in the patient visits and absolute number of patients taken care of by the public facilities in the areas. Lower West Neighborhood Health Center, Station 16, and the South Lawndale Health Center. These three centers had a total of 175,000 patient visits in 1986, 10 percent of whom 17,000 were for prenatal care. At Cook County Hospital, 1 of every 10 mothers who delivers comes from the Pilsen-South Lawndale area. Thus, the rate of medical indigency is higher among the Latina patients going to public facilities in such large numbers. The vast majority are not citizens nor permanent residents and therefore do not qualify for public assistance. Even though many of the husbands of those who are married are working, rarely do they have insurance, and if they do, it usually is a very restricted major medical policy for themselves only, not including spouses and children.

Childbearing patterns in Latinas. Recent studies in California and New York City show significant data exists for differences between women born in Mexico or Puerto Rico and those born in the United States. It shows the need for increased programs for both groups.

In the California study there were significant statistical differences between the percentage of women born in Mexico having children under the age of 18 as compared to those born in the United States, 5.0 vs. 9.3 percent. This puts more Latinas born in the United States at a high risk. The result among Puerto Ricans in New York City were even more striking, 6.9 versus 15.5 percent.

On the other hand, Mexican and Puerto Rican Latinas born in their native countries were much more likely to have children over the age of 35 years old than their U.S. born counterparts, putting them and their fetuses at high risk. In California study, it showed that 7.9 percent of Mexican women bore children over the age of 35 years, versus 3.8 percent of Latina born in the United States. In New York City, the figures are even more dramatic. The first generation Puerto Rican women, 9.7 had children born to them past the age of 35, versus 0.7 percent for their second generation counterparts.

We do not, of course, have statistics for Chicago, since the State of Illinois does not have Latina or Hispanic as a classification on either birth or death certificates. If we did, and if the number of women bearing children past the age of 35 years old was taken into consideration, Pilsen/Little Village would rank near the top of the IMRI formula. This clearly should have been a part of the IMRI formula in addition to women under 20 years old.

Other significant statistics are percentage of women beginning care in the first trimester. In the California study only 58 percent of Mexican women began prenatal care in the first trimester, compared to 71 percent of their American-born counterparts. This lack of early care is just as much a problem in the Pilsen-Little Village area. Lack of access or late access may explain why the rate of both fetal and neonatal deaths in infants of Mexican-born women is significantly higher than for either their U.S. born Latinas, or white counterparts.

One statistic both Mexican and American-born Latinas have in common in the California study was the signficantly higher percentage than U.S. whites or blacks who had their children born in county facilities and state facilities. This is another indicator of medical indigency which is found at Cook County Hospital, where about one half of all women are Latina and the University of Illinois, where one third are Latina.

And if you are familiar with the U of I, the U of I just gave a message to our community, we will not take anybody who cannot pay for services. They have cut their hospital to a smaller hospital, and are going to be known as a research and teaching hospital. So that, again, cuts access to our people.

Prevalence of underweight children. Age 0 to 11 months. Although Latinas, especially Mexicans, do better in terms of low birthweight than U.S. blacks and whites in some cases, once the child is born, the frequence of underweight babies is greatest among Latinos, 8.2 percent versus 5.4 percent in blacks, and 3.5 percent in whites.

PREVALENCE OF CONGENITAL ANOMALIES

Related to the greater number of Latina woman having children past the age of 35 years old is the higher rate of birth defects, particularly Down's Syndrome and Spina Bifida. At the Cook County Hospital, Spina Bifida clinic, about 80 percent of the patients are Latino. This may be true of other anomalies as well, but good statistics are not available.yet.

One of the things that struck close to me is that what you were saying and what Jennifer was saying is we want to put faces to our community. As I look in this audience, there are not many Hispanics here, and I am very glad that there was an outreach in our particular case I know phone calls were made. But we believe clearly that this Commission and any other policy makers at the Federal, State and local levels need to address the unique needs of our rapidly growing population. We are young, and work, but are underinsured or not insured, and ineligible for many government-funded programs to the exclusionary criteria. Our community here is eager to engage in a dialogue to begin to solve these problems. We need to see revision of eligibility criteria. What are we talking about? We are talking about the infant mortality reduction in this area, the WIC, the poverty criteria use of public aid leaves us out. We need to see the development of synthetic health insurance programs with low monthly premiums for the working poor. We are aware that the Chicago health systems agency is in the planning phase of such a program.

I will submit for the record, now, when I am finished, a description of Project Alivio, which was born in response to the unmet needs.

It is a center—a health care facility in Pilsen-Little Village and Back of the Yards for Service—especially service for those who are not insured, or underinsured, and it has three components, including delivery of health care services, a strong research and evaluation component, an education, training and employment component, which addresses the shortage of Hispanic Health Care professionals at all levels, and a day care component.

I would be happy to discuss this in detail later, and I thank you for listening.

[Prepared statement of Carmen Velasquez follows:]

PREPARED STATEMENT OF CARMEN VELASQUEZ, BOARD MEMBER, PROJECT ALIVIO, CHICAGO, IL

My name is Carmen Velasquez, Board member of Project Alivio and I appreciate the opportunity to address the Deomocratic Selection Committee For Children, Youth and Families. My testimony will focus on health issues in three predominantly Hispanic communities, Pilsen, Little Village and Back of the Yards.

As you already know; Hispanics comprise the fastest growing population in the City of Chicago. Latino Institute Research projects that, if the currect rate of population growth continues, Hispanics will constitute, by the year 2000, 24% of the City's population.

In the 1980 Census, Hispanics already accounted for 21% of the population under 15 and 24% of the population under 5.

Pilsen, Little Village and Back of the Yards, three predominantly Mexican communities in Chicago, comprise 25% of the total Hispanic population in the City. The following statistics directly relate to these communites are documented by South Lawndale/Pilsen Comprehensive Health Network.

Live Births: The birth rates per 1000 for South Lawndale and Pilsen rank first and second respectively among the 77 community areas in the entire City of Chicago come from these two community areas. Statistically these areas are among the two to three youngest areas of the city, so we can assume the high fertility rates will contnue. It is essential that we begin to deal with these high rates and future prevention of morbidity and mortality of infants in the community.

Mothers under 20: In absolute numbers the two communities rank 11th and 18th respectively in births to mothersunder the age of 20 years old. This is another reflection of the youth of the community which does not show signs of aging at this point.

Medical Indigency: The Latino Institute survey indicates the rate of medical indigency to be greater than 30% in the Pilsen-Little Village area. This was based on a phone survey in 1985. When the population who do not have phones is taken into account this rate will rise closer to 35-40%. In a face to face survey of 308 households done by the Latino Insitute in the summer of 1987 44.6% of 1,400 + persons were without medical insurance. This is reflected in the patient visits and absolute number of patients taken care of by the public facilities in the areas: Lower West Neighborhood Health Center (CDOH), Station 16 (CDOH), and the South Lawndale Health Center. These 3 centers had a total of 175,000 patient visits in 1986, 10% of whom (17,000) were for prenatal care. At Cook County Hospital 1 of every 10 mothers who delivers comes from the Pilsen-South Lawndale area. Thus, the rate of medical indigency is higher among the Latina patients going to public facilities in such large numbers: the vast majority are not citizens nor permanent residents and therefore do not qualify for public assistance. Even though many of the husbands of those who are married are working: rarely do they have insurance, and if they do it usually is a very restricted major medical policy for themselves only, not including spouses or children.

Childbearing Patterns in Latinas: Recent studies in California and New York City show significant data exists for differences between women born in Mexico or Puerto Rico and those born in the U.S. It shows the need for increased programs for both groups:

In the California study there were significant statistical differences between the % of women born in Mexico having children under the age of 18 as compared to those born in the U.S. (5.0 vs. 9.3%). This puts more Latinas born in the U.S. at high risk. The result among Puerto Ricans in NYC were even more striking: 6.9 vs. 15.5%.

On the other hand Mexican and Puerto Rican Latinas born in their native countries were much more likely to have children over the age of 35 years old than their U.S. born counterparts: putting them and their fetuses at high risk. In California study showed that 7.9% of Mexican women bore children over the age of 35 years vs. 3.8% of Latinas born in the U.S. In NYC: the figures are even more dramatic: 1st generation Puerto Rican women: 9.7% had children bore to them past the age of 35 years old vs. 0.7% for their 2nd generation counterparts.

We do not of course have statistics for Chicago since the state of Illinois does not have Latina or Hispanic as a classification on either birth or death certificates. If we did and if the # of women bearing children past the age of 35 years old was taken into consideration Pilsen/Little Village would rank near the top in the IMRI formula. This clearly should have been a part of the IMRI formula in addition to women under 20 years old.

Other significant statistics are % of women beginning care in the first trimester. In the California study only 58% of Mexican women began pre-natal care in the first rimester compared to 71% for their American born counterparts. This lack of early care is just as much a problem in the Pilsen-Little Village area. Lack of access or late access may explain why the rate of both fetal and neonatal (0-27 days) deaths in infants of Mexican-born women is significantly higher than for either their U.S. born Latinas or while counterparts.

One statistic both Mexican and American born Latinas has in common in the California study was the significantly higher % than U.S. whites or blacks who had their children born in County facilities: and state facilities. This is another indicator of medical indigency which is found at Cook County Hospital where about ½ of all women are Latina and the University of Illinois, where almost 1/3 are Latina.

Prevelance of Underweight Children: age 0-11 months: although Latinas, especially Mexicans do better in terms of low birthweight than U.S. Blacks and whites in some cases, once the child is born the frequency of underweight babies is greatest among Latinos: 8.2% vs. 5.4% (Blacks) and 3.5% (Whites). Source: Pediatric Nutrition Surveilance System. Centers for Disease Control, MMWR: 6/19/87. One reason may be the rise in # and % of children in poverty which is the fastest among all ethnic groups according to the Children's Defense Fund in Washington D.C. The figure now stands at close to 40%.

Prevelance of Congenital Anomalies: Related to the greater # of Latina women having children past the age of 35 years old is the higher rate of birth defects: particularly Down's Syndrome and Spina Bifida. At the Cook County Hospital Spina Bifida clinic about 80% of the patients are Latino. This may be true of other anomolies as well but good statistics are not available yet.

Clearly this Commission and any other policy makers atthe federal, state and local levels need to address the unique needs of our rapidly growing population. We are young, we work but are underinsured or uninsured; and ineligible for many government funded programs due to exclusionary criteria.

Our community here is eager to engage ina dialogue to begin to resolve these problems.

We need to see revision of elegibility criteria. (infant mortality reduction initative, WIC - poverty criteria used with public aid leaves us out)

We need to see the development of synthetic health insurance programs with low monthly premiums for the working poor. The Chicago Health Systems Agemcy is in the planning phase of such a program.

I will submit for the record, a description of Project Alivio which was born in response to the above unmet needs. It has three components:

1. Delivery of health care services,
2. A strong research and evaluation components,
3. An education, training, and employment component which addresses the shortage of Hispanic Health care professionals at all levels and,
4. A day care component.

I would be happy to discuss this in detail at a laterdate.

Respectfully submitted,

Carmen Velasquez,
Board Member
Project Alivio

(312) 666-4511
528-7390

SOURCES

1. Community Areas Ranked by "Need" Score: CDOH: 1983-1985
2. Live Birth Data including: Live Births, Mothers Under 20, Low Birthweight, Fetal Deaths, Perinatal Deaths, Post-neonatal Deaths: by community area: CDOH: 1985
3. Epidemiology of AIDS in Women in the United States: Journal of American Medical Association: pp. 2039-2042: April 17, 1987.
4. National Centers for Disease Control (CDC): Summary national statistics for Total number of cases of AIDS in Children (under age 13) and by ethnicity: white, Black, Hispanic: July 6th, 1987.
5. Childbearing Patterns Among Puerto Rican Hispanics in New York City and Puerto Rico: Topics in Minority Health: Morbidity and Mortality Weekly Report: V. 36, #3: 1/30/87., pp. 34-41.
6. Pregnancy Outcomes among Spanish-surname Women in California: Williams, et. al., American Journal of Public Health: V. 76,#4, April, 1986: pp. 387-391.
7. Nutritional Status of Minority Children-United States, 1986: MMWR: V. 36, #23, pp. 366-369: 6/19/87.

How Can You Support Project Alivio?

A wide spectrum of resources are needed to ensure the success of Project Alivio.

Funding from individuals, foundations and corporations is needed for new construction and to supplement over $1 million already committed to this health initiative.

Personal resources including community volunteer work and agency referrals at all levels are also needed to make Project Alivio a success.

Offers of cooperation, publicity and public relations are welcome.

If you want to help Project Alivio succeed, Please contact:

Mary Moreno
Project Alivio Chairperson
(312) 838-4838

or

Development Office
(312) 567-2114

Project Alivio Governance

Richard A. Daley College
Mary Moreno, Assistant to the President

Mercy Hospital and Medical Center
Sister Sheila Lyne, R.S.M., President

Latino Institute
José Matos Real, Executive Director

El Valor Corporation
Vincent A. Allocco, Ph.D.,
Executive Director

Fiesta Educativa, Inc.
Carmen Velásquez, Bilingual Consultant

United Neighborhood Organizations
Daniel Solis, Executive Director

St. Xavier College
Mary Lebold, R.N., M.S.N., Ed.D.,
Assistant Dean of Nursing

At-Large Members

Ann Garcelon, M.D.
Jodi Martínez Martin, Ed.D.
Angela Pérez Miller
Luis R. Muñoz, M.D.

These agencies and their representatives constitute the Board of Directors of the project with Mercy Hospital being the fiscal agent. This board has established by laws and set policy, thus ensuring a unique collaboration of the various actors in the joint governance of the program. The Board of Directors will be augmented as the project evolves, with an Advisory Board including lay leadership from among the clients as well as key institutions.

PROJECT ALIVIO

Project Alivio is a comprehensive health care program focused on the needs of Hispanics residing in three contiguous neighborhoods — Pilsen, Little Village and Back of the Yards. Approximately 125,000 Hispanics, comprising nearly 25 percent of the total Hispanic population of the city of Chicago, reside in this area. Health care services will be provided through a center at 23rd and Western, which is easily accessible to residents of all three neighborhoods. Services will include primary care, laboratory and X ray, and a health promotion program. Early childhood education and sick child daycare are under discussion.

Background

Project Alivio began in June 1986 as a collaborative effort of Mercy Hospital, several Hispanic community based agencies and two educational institutions. It was fiscally launched in March 1987 with a Chicago Community Trust three year start up grant of $803,200. The Directors of Project Alivio are now engaged in raising the balance of the funds needed for project implementation.

Components of Project Alivio

Delivery of Health Services. A new, community-based health center for comprehensive primary care will be constructed in a culturally-appropriate style at the crossroads of the three target community areas. Due to open in early 1988, services of Project Alivio will be offered in cooperation with Mercy Hospital and will include a bilingual 24-hr. answering service.

The center will provide the following services:

- Health maintenance
- Health promotion
- Minor emergency care
- Intervention and management of medical problems
- Laboratory and X-ray services
- Community volunteer services
- Social services and counseling
- Home health care
- Referrals

Education, Training and Employment of Hispanics. Hispanics are underrepresented in health professions. St. Xavier and Richard J. Daley Colleges will play key roles in the recruitment and training of bilingual and bicultural personnel, beginning with student awareness of health careers at the high school level.

Research. The Latino Institute will undertake research and assessment in the three target Hispanic communities to determine needs, to assure that services are meeting needs, and to evaluate the effectiveness of the project.

Development of a Financial Plan. The continuation of health services beyond the start-up grant will be provided by a plan that will include philanthropic funds to underwrite services for patients unable to pay.

Goals of Project Alivio

- To increase Hispanic access to comprehensive, affordable, quality health care.
- To promote effective communication between Hispanic patients and health providers through the availability of bilingual and bicultural professionals.
- To increase the Hispanic community's knowledge and understanding of wellness, and factors leading to ill health.
- To increase the representation of Hispanics in health care professions at all levels.

Need for Alivio

Hispanics remain, for the most part, marginal to traditional health and human care systems in the city.

Factors of youthfulness, many women at childbearing age, tendency toward large families and reliance on home remedies lead to the anticipation of heavy demands on the health services to be offered.

Health Care With A Difference

Project Alivio is unique in that it was designed to respond to the needs of the community, recognizing that health care delivery must be culturally sensitive to the potential client. Consequently, it reflects the initiative of the Hispanic community and is being planned and implemented with participation and support of individuals and organizations representing the community.

Additionally,

- The project's health center will include evenings and weekends in its regular hours for easier access. Patients will be encouraged to call for appointments, but walk-ins will be seen as well.
- The center will serve patients of all socio-economic levels, including low income, uninsured, as well as the privately insured. It will provide a long-term financial plan for the underwriting of services for the medically indigent.
- Its impact on health care delivery services will be significant in that it will increase the pool of bilingual health care professionals at all levels.
- It will incorporate Hispanic volunteers drawn from the service area.
- It will draw upon the collective expertise, financial resources and time commitment of seven institutions representing health, education and social services.

Chairman **Miller**. Thank you. Dr. Brown, let me ask you, in your practices in Cook County, it was mentioned here earlier that when you refer someone for high risk care it takes 4 to 5 weeks wait. Is that in your experience?

Dr. **Brown**. It may be data to verify that. I cannot give you statistics. I have had a similar experience, yes. I am not allowed to get into——

Chairman **Miller**. Is that a common experience?

Dr. **Brown**. I have had that experience not infrequently. I wish I could tell you more. I am not authorized. I suggest you refer to Cook County Hospital. I wish I could.

Chairman **Miller**. Do you have any idea—again, it is somewhat anecdotal, unless there is other data—the number of patients that you see where their complications are a result of a lack of access to prenatal care.

Dr. **Brown**. Many of my patients do not come to clinic until they feel the baby move, which is well past the first trimester, at 16 to 20 weeks. Therefore, an opportunity to gauge how pregnant they are, what possible early risk factors that are intervenable are present has been entirely lost. Well over half the patients I deliver personally do not come to prenatal care until about 22 weeks. The latest I have had someone come and still come to clinic and still sit and register and make the appointment and go through all the heroics is 36 weeks. When we have a patient come in the first trimester, we are so thrilled, we nearly throw a party. Unfortunately, it is a unique experience for me, first of all, to have them come in in the first trimester.

Chairman **Miller**. You may not inquire as to why that is, because it is of little concern at that point, because you cannot go back and reconstruct that time in terms of care, but do they tell you why——

Dr. **Brown**. Many patients say that they had no way of knowing they were pregnant until the baby moved. They were not sure. They either did not know, or did not feel they could access methods of which they could find this out. Home pregnancy tests are about $15. Some of the issues you brought up earlier can take some time to present yourself to a clinic if you have no—or an emergency room if you have no funding to find out if you are pregnant. It is not considered emergency care in most emergency rooms.

Chairman **Miller**. Do you feel that a fair amount of that is wishful thinking that they are not pregnant?

Dr. **Brown**. It is fair. I think that what has happened, and this is my opinion, is it has become a community practice not to go for prenatal care until later on. And many of my patients tell me, well, my sister did not go, and she was OK.

Unfortunately, that is anecdotal, and it is not backed up by statistics, indicating that accessible early pregnancy care is directly relatable to low birthweight, and diminishing the number of low birthweight infants. So—and yet there has become a whole sort of cultural thinking for many patients about not going early, or like you said, wishful thinking. Especially in the adolescent patient, where denial is a normal part of their structure and they are going to deny it until the latest possible minute.

Chairman **Miller**. You mentioned one of your cases where the pregnancy was apparently a result of incest or sexual abuse in the family. And again, this is just calling upon your experience, but in the case of the young patient, any idea of what percentage are not dealing with the pregnancy because they are afraid of repercussions within the family?

Dr. **Brown**. Again, I cannot give you statistics, but I would say that in my experience that it is not infrequent. I do not think a week goes by——

Chairman **Miller**. Not infrequent.

Dr. **Brown**. That it is not infrequent. I would say that not a week goes by that a young lady presents to my clinic terrified about either being pregnant, suspecting that she is, or another account of sometimes misguided fantasy about some other complications related to ill information about family planning, about health care.

A lot of my time is spent with the nonpregnant adolescents just helping to straighten out what the data are and with the pregnant adolescents just trying to get them in and engage them, as was addressed earlier, if the system seems at all threatening or at all frightening to them, and often it does, you could lose them. They are not going to stay. You have to hook them in where they feel that it is an okay thing to do to come and get prenatal care. It is not a judgment on them. It is not where somebody is going to ask them questions about things that are going to scare them or hurt them. That has—that does not work on an assembly line. It only works through personal interaction through people that are trusted by the pregnant adolescent.

Ms. **Washington**. Excuse me. I would just like to interject at this point, because I find it interesting that you would ask Dr. Brown and no reflection on her, questions around why she thinks people would not access human services when we have, Mr. Useni and myself, both here, as well as Carmen, who are direct providers out in the community, who could probably give you more detailed information in terms of what is happening with the numbers of women who are coming into the clinics. She naturally sees them well after all the other intake information has already taken place. Most of the work that happens in terms of human services, in terms of helping them to access services, the barriers take place by the time or once they get to the doctor's office.

Chairman **Miller**. The question was—when she sees people as she related her caseload, highly traumatized cases—the issue was what are these cases telling her, to the extent that they are, of why they are in that particular situation, which is different from why people aren't accessing at the front end. Ms. Washington, the only thing I want to say is that once you have gotten past the point of the beginning access, the other questions should have been referred otherwise.

Dr. **Brown**. I would just like to say that for every patient I see, there are many, many more who do not make it past what Mrs. Washington is talking about. And I think I said in my statement that I do not think that these patients who do, through luck, or courage or fortitude, ever make it to the door to see me are unique. If I thought this was a situation that involved three cases, I would not be here today. This is for every patient I have here, I have to question myself literally how many hundreds—hundreds of young ladies are out there getting no adequate prenatal care, or none at all. And it is something that I live with very uncomfortably as I continue to practice medicine.

Chairman Miller. Thank you.

Mr. Coats. Dr. Weigel, you talked about a grant that the Board of Health has provided for the county.

Dr. Weigel. That is right, sir.

Mr. Coats. And that was specifically designed to practice care——

Dr. Weigel. No, sir. That was designed to provide prenatal care to the underserved.

Mr. Coats. But it was set at a level to cover the costs of malpractice.

Dr. Weigel. On a lawful basis, yes sir.

Mr. Coats. Now, are you saying that if malpractice insurance costs were at a lower rate, those services would be provided and the state would not need to provide the incentive for them?

Dr. Weigel. That is right, sir.

Mr. Coats. Are there efforts under way in the medical community to deal with legislation in terms of the malpractice laws?

Dr. Weigel. We have done that with the medical society for the last four or five years, trying to get a cap on the amount of malpractice. It is well known in this state that if you want to get a high malpractice judgment, you either go to Madison County or Cook County. And you are seeing judgments for $7 or $8 million, on something that he probably was not negligent for.

And so, the result of it is that malpractice insurance has gone up so high that most people—most obstetricians are thinking of quitting or moving to a state like Indiana, where it is only one third of what the same amount of coverage is in the State of Illinois.

And every time we brought it up to the legislature, unfortunately, the trial lawyers are lobbying against it, and it has always been turned down.

Mr. Coats. What kind of a cap are you trying to——

Dr. Weigel. We are—I believe we are talking about a cap of a half million dollars.

Mr. Coats. We appreciate the obstetricians moving to Indiana, but we probably are not producing babies fast enough to accommodate all the obstetricians who want to move there.

What are the prospects of legislative action in the next session?

Dr. Weigel. I do not know. We try every year. It might be interesting. We have only started this program. We have got the approval in the latter part of September from the county, so we are now implementing it. We already have 43 patients who have applied for help. Most of them are in the first trimester, and I think this is important.

Mr. Coats. This is a demonstration program for the county?

Dr. Weigel. Yes, sir. I understand from the paper last night that DuPage County, our neighboring county which is very high in tax monies got a grant, but they are sending their high risk patients to Loyola. They are not being taken care of in their private physician's office.

Mr. **Coats**. How much was your grant for?

Dr. **Weigel**. We—$265,000, and the county matched it.

Mr. **Coats**. Thank you.

Chairman **Miller**. Mr. Durbin.

Mr. **Durbin**. Dr. Weigel, are you saying that because of this matching grant that medicaid mothers have no difficulty getting into the private physician's office, and how much is this grant for each delivery?

Dr. **Weigel**. Approximately somewhere between $250 and $350.

Mr. **Durbin**. So if an additional $350 was being paid by the Department of Public Aid, what you are telling me is that in Kane County, we would not be meeting here today.

Dr. **Weigel**. That is right, sir.

Mr. **Durbin**. I would like to ask just one other question in order to try to get one point clear, and I want to make sure that I direct it in general to the folks that are in the community here. It is clear to me from what we have heard that we clearly have an educational component here. That is teaching young mothers the critical need for them to get in and see doctors as quickly as possible. We have read and heard about programs where folks are actually out knocking on doors to get that message out. Right now the Department of Public Health told us this morning that they have got a TV and Radio campaign going on and they put posters up in offices, too, and they are suggesting to us that that community education program is going on. What is your experience? Is the State doing such a thing? Is it adequately being done by any agency?

Ms. **Washington**. To answer your first question, I think that you do have to do health education on every level, because most people only talk about health care when they—once they get pregnant. But health care is an ongoing issue that you have to help young women and young men understand the importance of making sure they are healthy during all of their formative years. And so in terms of the active campaign that is out there, that is working, I think that without a doubt all of us within the infant mortality networks feel that we are making an impact. To what extent and to say to you that we have been able to make an impact and we know that *x* number of women and *x* number of men are actually in the services, we cannot tell you that for sure.

But give us one year, because we are now tracking it in such a way that we will be able to give you the statistical data in terms of how many of the young people who use provided health education to continue health education on an ongoing basis, and that is what we think will impact infant mortality, because we know it is not a one generation problem, but a two to three generation problem.

Ms. **Velasquez**. I would say the same for our community. Not only are you dealing with language, but in terms of culture or lifestyles that say you do not talk about certain things with anybody, so health educators are going to be more and more important to us as time goes.

And talking about sex abuse, high school students, you do not know about that until it is really traumatic. And you do not say, hey, as in any other community, but there is an awful—there is a desperate need for education. That is why in one of our projects, this Project Alivio that I am talking about, education is an essential—it has to be part of our health care delivery.

Mr. **Durbin**. I would—yes?

Mr. **Perkins**. I would just like to add I think the public schools have to assume a greater responsibility in providing education to young people, because those are the formative years. Those are the years that young people are impressionable and gain their values, and I think public schools have to be getting into sex education and other related forms of health education. Kids need to learn very early, you may not have this problem of young women not going to the doctor, going early pregnancy, getting prenatal care if more education and understanding of sex was provided.

Mr. **Durbin**. I might just say and I mentioned in this morning's hearing that we live half our lives in Washington, DC. You cannot turn on the radio or television in that town which has, according to statistics we have been given, the highest infant mortality rate of any City in the United States—you cannot escape their ad campaign, which is entitled 'Beautiful Babies Right from the Start.' It just keeps the message coming from every television star and movie star you can think of, sports figures, trying to convince young mothers to get up and go to the doctor as fast as they can. And frankly, I think that it is critical for a major urban area like Chicago to get the kind of information out that the Beautiful Babies Campaign is doing in Washington D.C.

Dr. **Brown**. I just wanted to say it is too late when they come to see me. What you are talking about, and what you are talking about is what really matters. And by the time they come into the physician, it is a limited experience. I think there is a real need for a comprehensive educational program that expands over every aspect of society. And I think that would reduce what I am seeing and the fact that we spend untold millions of dollars in perinatal units with sick, sick, babies, struggling to keep them alive, and we could start way before the mother is ever pregnant, and start that education and prevent that catastrophe before we have the result.

Mr. **Durbin**. Thank you.

Chairman **Miller**. Congressman Hastert.

Mr. **Hastert**. Thank you, Mr. Chairman. I would like to start with Ms. Velasquez. You had some fairly good points in your testimony, and you truly came down to focus on some of the crux of what we are talking about this afternoon. When previous persons testifying talked about centering in the Church, we talk about education here, in your community, what role do you think—is the church playing any role in this problem of—trying to solve the problem?

Ms. **Velasquez**. Well, in the project I am in, Project Alivio, we are using—we are connected with a church-based organization, so we go to them—in fact, just a couple of Sundays ago to them in the Masses, making certain announcements. So they are taking an active part in what is happening here. They are looking for volunteers from the different churches. The kinds of things Jennifer was talking about. What role the volunteers have, and they have to come from our different communities, because if they do not, it is going to be another farce.

Mr. **Hastert**. In the community, do you access all those people, or a great percentage of people in that community?

Ms. **Velasquez**. A good percentage, yes. The network of the Church, Masses, and all the other activities that go on, are terrific. In addition to our organizations and our agencies, there is a whole network in our three communities of Pilsen, Little Village and Back of the Yards.

Mr. **Hastert**. So there is really a—and if you get the word out, get the information out, then you can start some of these projects.

Ms. **Velasquez**. Yes, I think so, and we are working with other deliverers of health care, so we are within the vacuum. Dr. Brown is one of the people here present.

Mr. **Hastert**. Dr. Brown, I am interested in your testimony, too, and you talk about your background and you come from a family of poverty or working poor, or whatever you——

Dr. **Brown**. My Dad was an unemployed steelworker. I am sure you are familiar with the steelworker.

Mr. **Hastert**. And then to be a doctor, it takes a unique person of perseverence to do that. How do we get other Dr. Browns in the process? Do you get paid enough? Do you waste away by the high-cost malpractice insurance? How do you survive?

Dr. **Brown**. The Family Practice Residency Program that I trained at at Cook County specifically solicits and tries to train people who are interested in taking care of the poor in both urban and rural settings. In my class, seven-eighths went to underserved areas, many of whom would have liked to have stayed urban, but were forced by national health commitments, to go to rural areas. I can think of four individuals out of twelve who would have stayed in Chicago if it had been up to them. The classes coming up through our program. And I see on the selections and promotion committee who chooses our residents, one of our main criteria is a commitment to care for the poor. We also actively solicit and encourage minority residents.

But we are hoping, and I think the years have proven. I do not have the statistics with me, nor would I probably be authorized to give them, but over the years our graduates have gone into the area, I think it takes a nurturing environment, I think it takes the philosophy, a belief that health care is a right not a privilege. Yet I know in this city that there is at least one area where that exists, and I am very proud to be part of it.

Mr. **Hastert**. How long is your committment? How long before you burn out? We see Dr. Weigel over there who served the community for 37 years. Are you——

Dr. **Brown**. We have physicians in our department whom I admire greatly who have been at this for all of their professional life.

I have—I am very good at taking care of my own personal resources, as anyone who knows me will attest and I have ways of handling burn-out. That is another issue that needs to be addressed.

I think my message to you today is I can tell you of dozens of physicians both young and old who are trying desperately to deliver health care to the urban poor. And are committed to it. We cannot—the days are gone when I can go out and open a solo practice in the neighborhood my parents raised me in. I am unable to do that. I do look forward to——

Mr. **Hastert**. Why?

Dr. **Brown**. I do look forward to working in community health centers that are federally funded. There are a number of our graduates that are very intimately involved with continuing it at Cook County. These are the opportunities our people are looking to, and those are fantastic settings. The job is being done. I marveled when I was in medical school. Everybody told me, you can't do that. You are unable to—go to the suburbs and practice there, because it is impossible to give good care to poor people on an individual basis. At Cook County in our residency, I found out it is not, but it ain't easy. And we need your help, your funding. We have the people.

Also, when I went to medical school, I could take student loans, and I lived, in 1983, on $3,500 outside of my school expenses, in the State of Illinois, city of Chicago. However, I was able to live and to get the loans to pay my tuition. The cost of educating physicians like myself has soared. The loans have not soared. I think the door has effectively been slammed shut on lower middle-class physicians such as myself, and I do not think that will bode well. I think another great opportunity would be to recruit people that have shown empathy, commitment and understanding of a lifestyle, because perhaps they, too, had lived it. Yet I do not see that happening and it makes me very, very sad.

And so I put the ball back in your court. Funding Physicians in that way for education for the underprivileged and also the community-based health centers have been—every time I am down there, I am overjoyed and enriched about how we can provide help.

And I also think the ACEF program, I am familiar with that, and it is a fantastic program. There are people out there doing the work. We could use a hundred more of every one of those clinics, and we would still be busy 12, 15 hours a day.

If you do not want us to burn out, give us more of us.

Mr. **Hastert**. Dr. Weigel, I appreciate you coming too, especially since you have been in business for a lot of years. And I think you realize that we do not have all of the answers, and every part of the state, and every city is different in its problem. And certainly the work that you have done and the fellow doctors and pediatricians in your area are making a contribution, too, and I think it is interesting to see what your record is, so we will be watching with interest, and certainly appreciate your spending time with us today. And opening up this new area.

Thank you, Mr. Chairman.

Chairman **Miller**. How many family practice residencies in the hospital——

Dr. **Brown**. In terms of the urban care?

Chairman **Miller**. No; how many are there in the country?

Dr. **Brown**. I do not have the exact number. In Chicago, I believe there are eight or nine. But we are the only ones that take care of the urban poor. We are sort of unique throughout the nation, for being in an urban care-type setting. There are other programs set up to do that, I am sorry I do not have those figures.

Chairman **Miller**. There are not many programs for residents to specialize in family practice?

Dr. **Brown**. It is growing. No, it is growing.

Chairman **Miller**. It is growing, but it is still—

Dr. **Brown**. I am sorry, but I do not have the data.

Chairman **Miller**. Thank you very much for all—excuse me.

Mr. **Perkins**. I just want to make one brief statement. There is another side of this problem which I do not think we elaborated on. And of course we have to improve the quality of health services, but that is just part of the problem. And until we improve housing, provide jobs and tackle some of these critical social issues in our communities, we can have the best health services, every child could receive prenatal and postnatal care and come back to these impoverished communities, and we would still have infant mortality and infant morbidity. We have to address ourselves to the other problems that Commissioner Edwards touched upon today that are just as important in impacting this problem as the health problem, and I would like this Committee to—and this is why we say funding is important. We want to say, well, we are providing funds, but you are not providing funds for the number of social service programs that have been cut over the past 4 or 5 years. The high unemployment. I mean, it is just awesome. And those problems cannot be ignored. This is why we look at it as a total problem, in terms of the quality of life.

I just wanted to make that statement.

Chairman **Miller**. Well, we share your concerns and that is the purpose of this Committee. I am sure the members of this Committee, after their four or five years of service on this Committee, more so than any other members of Congress, realize the total environment of low income and impoverished people in this country. And at the moment we are just looking at this small little question of access of these people in their own communities to prenatal and infant care, but I do not think anybody sits here believing that we can deal with this in a vacuum. This is still an environmental problem for poor people in this—not just in the state of Illinois, but in the entire country.

Thank you very much for your time and your testimony. The Committee stands adjourned.

[Whereupon, at 5:25 p.m., the hearing was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF JAMES CRAVENS, M.D., PRESIDENT, ILLINOIS CHAPTER, AAP; H. GARRY GARDNER, M.D., VICE PRESIDENT, ILLINOIS CHAPTER, AAP, VICE PRESIDENT, CHICAGO PEDIATRIC SOCIETY

The Illinois Chapter of the American Academy of Pediatrics (AAP) and the Chicago Pediatric Society appreciate the opportunity to present our views on measures to alleviate the infant mortality crisis in Illinois. The Illinois Chapter of the AAP represents nearly 1,000 pediatricians throughout the state and the Chicago Pediatric Society nearly 600 pediatricians in the Chicagoland area. Both are leading child health advocacy organizations in the state.

In 1986, the infant mortality rate in Illinois stood at 12.0%; 0.4% higher than in 1985 according to the Illinois Department of Public Health. Illinois' infant mortality rate is the highest among any northern state and is among the top 10 in the nation. Subgroup data is even more disturbing with 22 infant deaths per 1000 live births for blacks as compared to 9.5 for whites in 1984 according to the Children's Defense Fund.

Rates of infant death are not evenly distributed throughout the population. Infant mortality rates are known to be higher among low income segments of the population with limited access to health care and little understanding of the benefits of early and preventive health care. Compromised nutritional status as judged by lower prepregnancy weight and lower weight gain during pregnancy is associated with poor pregnancy outcomes.

Teenage mothers are also a high-risk group. Babies born to teens are at a higher risk of low birth weight, a leading factor in infant mortality.

Although the causes of infant mortality are numerous and complex for these two high risk groups, a number of approaches are known to reduce the risk of infant death. Access to perinatal care and primary care for high risk women has clearly been shown to reduce the risk of infant mortality. Perinatal care includes prenatal care, intensive services for high risk infants at birth, and appropriate follow-up care. Evidence unambiguously shows that prenatal care early on during pregnancy can reduce some factors leading to low birth weight, a major contributing factor in neonatal mortality.

The State of Illinois has the opportunity to increase access to perinatal care for low income women and infants. The Omnibus Budget Reconciliation Act of 1986 grants states the option of expanding Medicaid eligibility to poor pregnant women and infants whose incomes do not exceed the federal poverty level. In Illinois one half of the cost of these medical services will be paid with federal dollars.

Governor Thompson recently signed SB 833 into law. While this act authorizes the Department of Public Aid to extend Medicaid eligibility to pregnant women and infants whose family incomes are in excess of the state's AFDC and medically needy levels but below the federal poverty level, it does not specify an implementation date or eligibility standards. The Illinois Chapter of the AAP and the Chicago Pediatric Society urge the Department of Public Aid to implement the expanded eligibility option immediately and to set the income requirement fully at 100% of the federal poverty level.

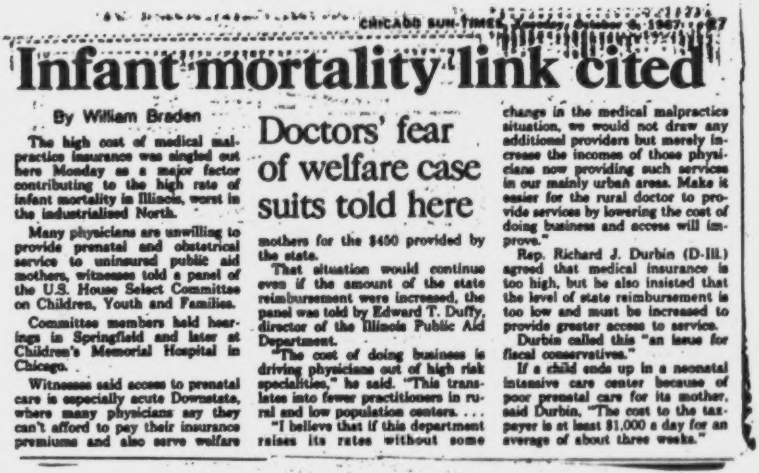
Expanding Medicaid eligibility to pregnant women is not the only measure needed to increase access to perinatal and primary care. Once pregnant women and infants attain eligibility, they must be able to receive quality medical care. Reimbursement rates for physicians are inadequate in Illinois. Many pediatricians limit their participation or even elect not to participate in the program because it is financially infeasible. Pediatricians do not have the excessive malpractice premiums to pay that obstetricians do and are therefore more likely to participate in the Medicaid program if fees are raised.

A study conducted by the American Academy of Pediatrics on pediatrician participation in state Medicaid programs between 1978 and 1983 showed that participation is affected by level of reimbursement, administrative complexity, and generosity of the program in terms of benefits. The analysis concludes that raising levels of reimbursements, simplifying the paperwork and procedures involved, and expanding benefits would increase pediatrician participation.

Illinois may be afforded the opportunity to creatively improve the participation of pediatricians and obstetricians in the Medicaid program. The Medicare and Medicaid Budget Reconciliation Amendments of 1987 (HR 3188) contains a provision to fund demonstration projects to reduce infant mortality and morbidity by improving the access of eligible pregnant women and children to obstetricians and pediatricians.

The types of projects that could be considered if the bill is enacted include: improving reimbursements, expediting reimbursement, innovative payment mechanisms such as global fees for maternity and pediatric services, paying for medical malpractice insurance or sharing in liability risks, alleviating administrative burdens in submitting claims, guaranteeing continuity of coverage and covering medical services that are needed by high-risk pregnant women and infants. We urge the members of the Select Committee on Children Youth and Families to support the funding of these valuable demonstration projects.

Opportunities to decrease infant mortality by increasing access to perinatal care for pregnant women and infants do exist in Illinois. It would be a disgrace if our state did not take advantage of these options. Babies born in Illinois are our future; we must invest in their health and well being.



CHICAGO SUN-TIMES, Tuesday, October 6, 1987 27

Infant mortality link cited

Doctors' fear of welfare case suits told here

By William Braden

The high cost of medical malpractice insurance was singled out here Monday as a major factor contributing to the high rate of infant mortality in Illinois, worst in the industrialized North.

Many physicians are unwilling to provide prenatal and obstetrical service to uninsured public aid mothers, witnesses told a panel of the U.S. House Select Committee on Children, Youth and Families.

Committee members held hearings in Springfield and later at Children's Memorial Hospital in Chicago.

Witnesses said access to prenatal care is especially acute Downstate, where many physicians say they can't afford to pay their insurance premiums and also serve welfare mothers for the $450 provided by the state.

That situation would continue even if the amount of the state reimbursement were increased, the panel was told by Edward T. Duffy, director of the Illinois Public Aid Department.

"The cost of doing business is driving physicians out of high risk specialities," he said. "This translates into fewer practitioners in rural and low population centers. . . .

"I believe that if this department raises its rates without some change in the medical malpractice situation, we would not draw any additional providers but merely increase the incomes of those physicians now providing such services in our mainly urban areas. Make it easier for the rural doctor to provide services by lowering the cost of doing business and access will improve."

Rep. Richard J. Durbin (D-Ill.) agreed that medical insurance is too high, but he also insisted that the level of state reimbursement is too low and must be increased to provide greater access to service.

Durbin called this "an issue for fiscal conservatives."

If a child ends up in a neonatal intensive care center because of poor prenatal care for its mother, said Durbin, "The cost to the taxpayer is at least $1,000 a day for an average of about three weeks."

Prepared Statement of Joyce R. Scott, M.A., Executive Director, West Side Future, Chicago, IL

As you are clearly aware, due to the fact that you convened hearings in Illinois, we are facing a serious situation with Infant Mortality. Once all of the statistics are related, we are still left with the question, Why? That is for some a particularly perplexing question in the community that West Side Future serves.

Our target area is Community Area #28-the Near West Side of Chicago. Located within this area is the Medical Center Complex. It is comprised of three (3) major medical institutions. Each of these facilities is a Perinatal Center. In other words, they provide the pinnacle of care to obstetrical patients and newborns. We also have within this community two smaller hospitals and numerous clinics, as well as, one large medical facility that is two (2) blocks beyond our boundary. Yet and still, we have the "highest" Infant Mortality rate in the entire city of Chicago. This area's statistics clearly validate the need for programming beyond medical issues.

The state and city Departments of Health realized over one year ago that new and creative programming was needed. Therefore, Infant Mortality Networks such as West Side Future were funded across the state. Each of the funded areas have some special problems. In this community one of the factors is "Access" to care. Clients that we serve are frequently intimidated by or not knowledgeable regarding entry into these large institutins. We are attempting to address this through (a) educating clients regarding available services, (b) functioning as their advocates with services providers and (c) educating service providers regarding the needs of a population that exists in their "front yard".

Although access to care is an important factor, the primary factor in infant mortality is the "quality of life" that exists in this area. Those individuals who are at greater risk and whose infants are actually dying are primarily residents fo the three (3) public housing developments. Approximately forty-three percent (43%) of community residents live within CHA Housing. The predominant numbers reside within massive high rise structures. They face on a daily basis all of the dangers and ills that have become an integral part of public housing existence. These are extreme poverty, inadequate nutrition, alcoholism, drug abuse, depression, teenage pregnancy and an ongoing litany of social ills. Although not always clearly seen, these problems are the primogeniture of infant mortality.

We will not combat this alarming situation until we begin to address these problems. A mother cannot give birth to a healthy infant if she cannot pay for or receive quality medical care; if she does not have an adequate diet; if she abuses alcohol or drugs and if the numerous other negative situations exist. When we move beyond the intra-uterine phase, these problems have an even greater impact. How can we expect survival or even adequate growth and development from an infant who returns to a home without adequate heat; without appropriate food, with parents who may be using drugs and with perhaps one parent who is isolated and single. We are, of course, also attempting to address these problems. However, we require assistance from a multitude of disciplines and organizations.

Coordinated delivery of service is an absolute requirement for success. Each woman must also be provided with quality prenatal care irregardless of ability to pay. This society has to also begin to shift priorities from high-tech "after the fact" delivery of care to a preventive mode of functioning. We must also recognize and accept that the survival of the infant is dictated by the "quality of life" and the optional functioning of the parent.

I want to thank this body for providing an opportunity to discuss this very important issue. Members of our Network also expressed a desire to present their statement. Therefore, I have attached prepared statements that were submitted to me for inclusion.

Sincerely,

Joyce R. Scott, M.A.
Executive Director
West Side Future

PREPARED STATEMENT OF EMILE BECK, RN, MN, PUBLIC HEALTH NURSE, CHICAGO, IL

My personal and professional concerns regarding the related issues of low birth weight, pre term delivery, and infant mortality are profound, since, as a practicing public health nurse in Chicago's community area #28, infant death (and the potential for infant death) are a fact of daily professional existence. Quite ironically, this same community area contains the world's largest medical center, so that "access to prenatal care" is not a major factor for my overwhelmingly Black---and to a limited extent, Hispanic---population for whom my staff cares. The presence of such extensive medical/educational institutions makes a mockery of our extremely high infant mortality rates, since the presence of sophisticated technology and literally thousands of health care professionals are nearly meaningless to the impoverished women who live nearby.

Despite those large medical systems, the poverty in community area #28 is deeply pervasive. 44,000 residents live in three massive Chicago Housing Authority complexes; these structures are filthy, horribly-maintained, and sometimes dangerous and most residents seem truely powerless, by themselves, to affect any kind of positive change. Mounds of garbage, in which children play, serious crime, and drugs are daily facts of life; existence, for the greater part, is stressful. Given the bleakness of the physical environment, there almost seems to be a gigantic "cube" of hopelessness and/or a community-wide shared depression that measures approximately 3.5 miles by one mile wide and extends upward for fourteen stories---roughly the boundaries of the Henry Horner Homes, which I visit almost daily. Welfare, which ought to provide basic subsistence, actually becomes, for prenatal patients, a non-medical, socioeconomic risk factor that, within this geographic context, practically guarantees an exceptional level of dead babies. We do not lack for either work or challenge.

A major factor and problem for myself and my staff is nutrition among prenatal patients. It has been recently shown in the research, that the most significant factor in pre term birth (accounting for 60% of the increased risk of premature births to Black women) is the hematocrit level---in effect, a measure of anemia. We do not have enough time, nor nearly enough staff to teach, to educate, and to follow-up as we would choose, consistent with our professional training---and I am convinced that we could make a considerable difference, had I enough caring nurses to work on the deceptively simple problem of nutrition. It amazes me that the City and society provides enough policemen and firemen, but not nearly enough public health nurses and, while we will not tolerate crime and fires, the society will tolerate an extremely high level of dead children, which, in most Third World nations would be considered outrageous! Perhaps the vast majority of Americans do not see the poverty, nor do they experience the pain and suffering that surrounds the death of a child, especially a poor child.

Finally, I am deeply concerned that extensive financial resources are directed toward sophisticated technology, mainly in modern neonatal intensive care units, while very little money is allocated to either prevention of pre term, low birth weight deliveries or directed to resources for community follow-up after hospital discharge, since the infants involved are at considerable risk. Again, more and the more efficient use of public health nurses, certified nurse-midwives, and pediatric nurse practitioners could affect the problem (and in a very cost-effective manner), if public policy favored this approach.

Thank you for the opportunity to make a written statement on this very important subject and my thanks also to Joyce Scott, M.S.W., who made the opportunity possible.

Emilie Beck, RN, MN
Public Health NurseII

PREPARED STATEMENT OF NOREEN M. SUGRUE, DIRECTOR, RESEARCH AND EVALUATION, THE BETTER BOYS FOUNDATION, CHICAGO, IL

This committee is concerned with children--their health, education, and economic conditions. As such the concern also must be with families. For too long fathers have not been attended to when policies and programs designed to assist children have implemented.

The quality of life and the services available to a child largely depend on the economic status of her mother. Historically, legislative initiatives aimed at children also have been aimed at women. The structuring of policies in such a way points to the reality that the status of a child is tied to the status of a mother. In order to improve a child's life, a mother's life also must be improved.

The implication of and ideology tied to such legislation is that the father is present at conception, but not expected to be around after that. Oh sure we all want things to be different, talk about ways to make things different, and try to encourage fathers to become viable and visible figures in the lives of their children.

In reality all too many a father is not part of his child's life after conception, and as such, short-term policies and economic initiatives to assist children must be structured with that in mind. However, the long term policy and program strategies must be structured to encourage and support maximum social, psychological, and economic support by fathers in the lives of their children.

The psychological benefits of having both a mother and father participate in a child's life are well documented. Legislation which attempts to assist children yet penalizes such paternal participation can be charecterized as flawed, short-sighted, and detrimental to children.

The economic well-being of a child is vastly improved when a father is present. This is not to imply that economic assistance will not be needed if a father is present, all too often it will be. However, the family needing such assistace should not be penalized if dad is in the home full-time and/or economically contributing.

So many of the programs concentrate on the mother-child dyad and forget that there is a father to be dealth with. A glaring example of this is how the pediatric AIDS epidemic is being handled throughout the country. While the overwhelming majority of pediatric cases are due to perinatal transmission, the programs that are designed to work with and assist these children are aimed at mothers and children; the father is ignored or forgotten. Even if the parents are not married, as is the situation in most of these cases, there is a father that needs to be brought into the caretaking and caregiving processes.

What I encourage this committee to do is handle the short term needs of children, hence women, but also begin to evaluate current programs and projects in light of how they seek out fathers, how they work with them, and how they encourage rather than penalize their participation in all aspects of children's lives. Further, keystone to any new programs, projects, or legislative initiatives ought to be incentives for maximum paternal participation. Reaching out to fathers must become part of the overall strategy in improving the lives of our children.

We have an administration that claims to have families as a priority--surely this is true, but only in a rhetorical sense. The increasing numbers of children who live below the poverty level, whose habitats are shelters, and whose health and educational needs are grossly undermet indicate that families and children are convenient for rhetoric, but that they are undeserving of dollars and services needed to ensure that they have a minimally acceptable standard of living. Since the early 1980s there has been a dramatic decrease in the quality of life for a large proportion of the children living in the United States. This committee has to take the leadership in addressing the problems that have been around for decades, but because of current administration policies have become exacerbated since 1980. That task is enormous and will not be completed within a short time period.

Representative Barney Frank has stated that this administration believes that life begings at conception and ends at birth. The task for those of us who work with and for children is to ensure that from conception on minimal health, education, living, and nutritional standards are met for all children. In addition, policies and programs aimed at assisting children must include both parents. The underlying assumptions must be that mom and dad will be present in the life of their child. This is not to be taken as a naive statement that ignores the high rate of absentee fathers, rather it is a challenge to our leaders to begin structuring policies and programs which work at bringing fathers into the lives of their children.

So many of the initiatives designed to improve the lives of children are crisis driven and reactive. By that I mean that the programs are designed in response to a crisis with the hope of warding off future crises. The work of this committee can and should be proactive, not reactive.

While it is true that preventive programs appear more expensive than programs which attempt to 'fix' a problem, cost benefit analyses indicate that preventive programs are cheaper in the long run. One need only examine programs that prevent a youth from becoming pregnant, dropping out of school, or becoming malnourished to realize that for every $1.00 spent on prevention three to ten times that is saved in terms of what it would cost to 'fix' those problems later on.

The commitment to including fathers and designing proactive prevention programs will, in the long run, do the most for an individual child, a family, and society. It is incumbent upon this committee to get others to frame questions and solutions in new ways--ways which include two parents and which prevent a crisis rather than repair a crisis--and to structure policies and programs in ways that are consistent with this perspective.

Thank you.

Prepared Statement of Kathleen Kostelny, M.A., and James Garbarino, Ph.D., Erikson Institute for Advanced Study in Child Development, Chicago, IL

In the United States, death in the first year of life brings development to an abrupt halt for more than 40,000 children annually. The infant mortality rate in the United States in 1986 was estimated at 10.4 per 1,000 live births. This figure may seem low in contrast to the rates observed in most underdeveloped countries (e.g., 108.2 in Haiti, 143.4 in Ethiopia, and 204.8 in Afghanistan), but is higher than those in other developed countries. The U.S. tied for last place in a ranking of 20 developed countries for the years 1980-1985. According to the U.S. Surgeon General, given the United State's current state of medical knowledge and technology, the infant mortality rate should be no higher than 9.0. Some nations have surpassed even that figure: Sweden, Japan and Finland have rates of 7.0 or less.

Nationally, the infant mortality rate is approximately twice as high for black infants (at 19.2) as it is for white infants (at 9.7). Illinois' rate of 12.4 is the highest of any northern industrialized state and breaks down to 21.4 for black and 9.7 for white infants. Moreover, Chicago has one of the highest infant mortality rates in the country. In a study of the 22 largest metropolitan areas in the United States (cities of 500,000+ population) Chicago had the fifth highest rate after Washington D.C., Detroit, Cleveland and Baltimore. Among Chicago communities, infant mortality rates vary dramatically. In 1985 they ranged from 0 to 79.0. Chicago's overall rate of 16.5 (11.3 for white infants and 22.4 for black infants) represents a small increase for 1985, following only a small decline in the infant mortality rate since 1981. This reflects a national trend: a slowing down of progress in reducing infant mortality since 1981, after two decades of a steady, sustained, and significant decline.

Aside from merely recording deaths, infant mortality rates are useful indicators of the quality of prenatal and perinatal care for infants, and serve as indirect indices of potential developmental disabilities, a community's infant health, and the level of child abuse and neglect (Margolis, 1987). Infant mortality has been associated with demographic characteristics such as maternal age, socioeconomic factors such as poverty, and public health problems such as the lack of adequate prenatal care. A primary risk factor of infant mortality is low birth weight, which directly affects the fetus' chance of survival, while secondary risk factors such as young maternal age are demographic characteristics. Furthermore, tertiary risk factors involving types and access to health services reflect community level influences. This identifies the problem squarely within an ecological framework, as micro-, meso-, exo- and macrosystem influences are clearly evident (Garbarino and associates, 1982).

One of the strongest correlates of infant mortality is low birthweight. The National Infant Mortality Survey found that the most important single predictor for infant survival was birthweight, with an exponential improvement in survival by increasing the birthweight to optimum level. It has been estimated that infants of low birthweight are 40 times more likely to die in the first month of life than infants of normal birthweight, accounting for more than 60% of all deaths in the neonatal period (Samuels, 1985). The U.S. ranked behind 17 other industrialized countries with 6.7% of all births being low birthweight (e.g., Sweden and Finland's percentages were 3.6 and 3.9 respectively). Mortality due to prematurity reflects pre-existing biologic conditions of the mother, inadequate pre-natal medical care, and adverse physiological changes. All are linked to the quality of the mother's social environment. Although there has been success in improving the survival of low birthweight infants, this achievement has not been accompanied by a parallel decrease in the frequency of low birthweight--the most important determinant of infant survival.

Teenage mothers are especially at risk for giving birth to low birthweight infants. The U.S. led the industrialized world in 1983 in this category, with 13.7% of all births occurring to mothers under 20 years of age. The birth rate for women aged 15-19 in the U.S. was 54 per 1000 compared to rates of 7 per 1000 in the Netherlands and 8 per 1000 in Switzerland (Miller, 1987). Infants born to teenage mothers are 1.4 times more likely to be of low birthweight than those born to older mothers, and neonatal mortality rates for infants of teen mothers are 1.5 times higher than for mothers over 20 years of age (Samuels, 1985).

Immature teenage mothers are especially at risk from both biological and socioeconomic factors. Biological problems include the teenage mothers' physiological immaturity for pregnancy and their nutritional needs for their own growth that compete with those of their fetuses. Incomplete education and reduced levels of economic well being are some of the socioeconomic risk factors. Additionally, the tendency of teenage mothers to avoid seeking prenatal care early in the pregnancy or even at all, contributes to a high rate of low birthweight and disabled infants.

Nationally, the leading causes of infant mortality of children less than 1 year of age are congenital anomalies (21.3%), sudden infant death syndrome (SIDS) (12.4%), respiratory related diseases (9.5), and low birth weight/prematurity (8.5%). In Chicago, however, a different pattern emerges -- the leading causes of death are low birth weight (52.8%), sudden infant death syndrome (19.8%), congenital anomalies (14.9%) and respiratory related diseases (5.7%). Chicago has a higher percentage of low birth weight infants--9.6% compared to 6.7% nationally in 1984. Even more alarming is that the number of infants dying due to low birth weight in Chicago is more than six times the national average. These disturbing figures point to the need for an analysis designed to illuminate the origins and correlates of Chicago's status as a high risk environment for infants.

The Chicago Department of Health conducted an analysis that identified Chicago communities at highest risk of infant mortality and in greatest need of services. Birth rates, prematurity rates, rates of births to teenagers, AFDC recipients, and infant mortality rates for the period 1979-1983 were examined. As a result, nineteen communities with the highest "need index" for maternal and child health services were targeted as being at greatest risk. These communities are part of the Infant Mortality Reduction Initiative for the State of Illinois, a project with the stated goal of reducing infant mortality to 9.0 by the year 1990.

Our analysis differs from the Chicago Department of Health study in three respects. First, it conceives of risk as more than simply the sum of infant mortality rates and predisposing factors. Secondly, it examines trends in infant mortality rates in order to make statements about the stability of communities as social environments for child bearing. Thirdly, it examines community level factors as possible explanations for different patterns of infant mortality.

Our previous research has generated a model which incorporates two meanings of risk (Garbarino & Crouter, 1978a; Garbarino & Sherman, 1980; Garbarino, Schellenbach, & Kostelny, 1987; Garbarino, 1987). In identifying high and low risk areas for child maltreatment based on the socioeconomic and demographic characteristics of communities, the model looked not only at absolute rates based on actual incidence in a given population, but also at rates that were higher or lower than would be expected in the context of what is known about a community's socioeconomic and demographic constitution. For example, two communities might have the same actual child maltreatment rate.

One community however, might be labeled "high risk" because its rate exceeded what it "should be" given its socioeconomic and demographic characteristics. In contrast, the other would be labeled "low risk" because its rate was lower than what would be "expected", given its socioeconomic and demographic profile.

Building on this model, the present research focused on four major issues: (1) which communities show stability in actual infant mortality rates; (2) which communities show stability in "predicted" infant mortality rates when socioeconomic and demographic variables are considered; (3) which communities show stability in predicted rates of low birthweight and births to teenagers given their socioeconomic and demographic profiles; and (4) what community level factors might explain anomalies in comparisons of predicted and actual rates, after accounting for the demographic impact of teen birth rates and low birthweight rates.

METHODOLOGY

In the present study, actual infant mortality rates were first tabulated for Chicago's 76 community areas for each year during the period 1980 to 1985. Each community area was assigned to one of three categories for each year. The first category (low actual risk) had rates that were at or below the national average for each of the six years under consideration, the second category (average actual risk) had rates that ranged from above the national average up to and including the average for Chicago, and the third category (high actual risk) had rates which were above the average for Chicago.

	Low Risk	Average	High Risk
1980	<12.6	12.6-20.7	>20.7
1981	<11.9	11.9-18.9	>18.9
1982	<11.5	11.5-18.6	>18.6
1983	<11.2	11.2-17.6	>17.6
1984	<10.7	10.7-16.4	>16.4
1985	<10.6	10.6-16.5	>16.5

Next, trends for infant mortality rates throughout this six-year period were analyzed for stability. This trend analysis is particularly important because the relatively small numbers of deaths involved mean that even small fluctuations in the number of infant deaths can have a great effect on the rates. This is particularly true for the smaller areas (i.e., population of 15,000, with 400 live births, where a 10.0 per 1000 rate means there were 4 deaths, but the addition of only 2 deaths raises the rate to 15.0 per 1000.) The highest actual number of deaths of any community for a given year during the period studied was 77. A chi square test was performed to see if the distribution of communities in the three categories differed from chance. Communities which exhibited patterns more often than expected by chance, i.e., occurring in at least three out of the six years, were considered to be stable, and were included in one of the following categories:

I-IM-A: Low actual rates of infant mortality for at least 3 out of 6 years

II-IM-A: Average actual rates of infant mortality for at least 3 out of 6 years

III-IM-A: High actual rates of infant mortality for at least 3 out of 6 years

Second, to determine predicted rates for communities, multiple regression analyses were conducted with infant mortality as the dependent variable and nine socioeconomic and demographic factors as independent variables. The nine independent variables obtained from the 1980 census were:

1) Black: Percentage of population who indicated their race as black, negro, Jamaican, black Puerto Rican, West Indian, Haitian or Nigerian.
2) Hispanic: Percentage of population who indicated Mexican, Puerto Rican, Cuban or other Spanish/Hispanic origin.
3) Poverty: Percentage of families living below the poverty level, e.g. $7,356 annually for a family of 4 in 1980 dollars.
4) Affluence: Percentage of families having annual incomes above $30,000 in 1980 dollars.
5) Overcrowding: Percentage of households having more than one person per room.
6) Female-Headed Households: Percentage of households with children headed by women.
7) Transience: Percentage of families living in present home less than 5 years.
8) Unemployment: Percentage of persons in labor force who are not working.
9) Education: Median education level.

The availability of socioeconomic and demographic data for only one year is a limitation of the present analysis. Moreover, changing community conditions in the period 1980-1985 are not reflected in these data. One measure of how serious the problem might be for the analysis is to determine whether or not the predictive power of the multiple regression analysis (as evident in proportion of variance accounted for, R^2) decreases as the socioeconomic and demographic data "age" from 1980-1985. The R^2 shows the following pattern: 1980: .35; 1981: .45; 1982: .69; 1983: .47; 1984: .61; 1985: .49. This reassures us that aging of the socioeconomic and demographic data is not a major problem for our analysis.

For each community, the analysis generates a predicted infant mortality rate plus its confidence interval. To be included in high or low risk categories, the difference between the observed and predicted rate had to be at least twice as large as the standard error of the mean (e.g., if the predicted rate was 14.2 and the standard error of the mean was 1.9, the range would be 10.4-18.0). As with the actual infant mortality rates, communities which showed patterns of stability for at least 3 of the 6 years were assigned to the following categories:

I-IM-P: Lower than predicted infant mortality rates for at least 3 out of 6 years

II-IM-P: Within the predicted range for infant mortality rates for at least 3 out of 6 years

III-IM-P: Higher than predicted infant mortality rates for at least 3 out of 6 years

Two additional variables were examined--rate of births to teenage mothers and rate of low birth weight infants. First, actual rates were examined and assigned to low, average or high risk categories using the method described for infant mortality. The ranges were as follows for births to teenagers:

	Low Risk	Average	High Risk
1980	< 15.6	15.7 - 18.5	> 18.5
1981	< 14.8	14.9 - 17.9	> 17.9
1982	< 14.2	14.3 - 16.9	> 16.9
1983	< 13.7	13.8 - 16.5	> 16.5
1984	< 13.1	13.2 - 16.5	> 16.5
1985	< 12.8	12.9 - 15.7	> 15.7

For low birth weight infants the ranges were:

	Low Risk	Average	High Risk
1980	< 6.8	6.9 - 9.5	> 9.5
1981	< 6.8	6.9 - 9.5	> 9.5
1982	< 6.8	6.9 - 9.5	> 9.5
1983	< 6.8	6.9 - 9.2	> 9.2
1984	< 6.7	6.8 - 9.6	> 9.6
1985	< 6.8	6.9 - 9.4	> 9.4

Multiple regression analyses were then run with the same nine demographic and socioeconomic variables; first for teenage mothers, and second for low birthweight infants. The same analysis of risk assignment and trends over time was applied to rates of both teen births and low birth weight babies. The categories included:

I-TB-P: Lower than predicted rates of teen births for at least 3 out of 6 years

II-TB-P: Within the predicted range for teen births for at least 3 out of 6 years

III-TB-P: Higher than predicted rates of teen births for at least 3 out of 6 years

I-LBW-P: Lower than predicted rates of low birth weight for 3 out of 6 years

II-LBW-P: Within the predicted range for low birth weight for at least 3 out of 6 years

III-LBW-P: Higher than predicted rates of low birth weight for at least 3 out of 6 years

RESULTS

Actual infant mortality rates for the 76 Chicago communities showed that 21 communities fell into the low risk category, 15 communities fell into the average risk category, and 39 areas fell into the high risk category. One community area fell into the both the low and high risk category. For low birth weight rates, 30 communities fell into the low risk category, 14 into the average risk category, and 32 into the high risk category. For rates of births to teenage mothers, 34 communities fell into the low risk category, 5 into the average risk category, and 37 into the high risk category.

Fifty-three (69.7%) of all 76 communities examined showed infant mortality rates within the predicted range (II-IM-P) for their communities. Of the 23 communities not explained by these socioeconomic and demographic variables, 11 (14.5%) were in the lower than predicted risk category (I-IM-P), 6 (7.9%) were in the higher than predicted risk category (III-IM-P), and in 6 communities rates could not be assigned to a category because they did not occur more or less than by chance, indicating ambiguous data or changing communities. Chi square was significant at the .001 level indicating that the distribution of communities to risk status differs from chance.

In the 11 communities in the lower than predicted risk category, 9 communities also had low actual rates, 1 community had average actual rates, and 2 communities had high actual rates. Thus, even though these 2 communities were high risk compared to Chicago's overall actual rate, they were low risk when compared to communities with similar socioeconomic and demographic characteristics. Identifying such anomalies is one important function of our analytic strategy.

In the 6 communities where the infant mortality rate was higher than predicted, 2 also had high actual rates, encompassing both definitions of risk. Two other communities had rates that fell in both the low actual and high actual categories, and 2 did not occur in any of the categories for at least three of the six years, exhibiting a fluctuating, unstable pattern.

The multiple correlations of socioeconomic and demographic conditions with births to teens and low birth weight were very high: ranging from .94-.96 for births to teenage mothers, and .91-.94 for low birth weight infants over this same six-year period. (Table I) Additionally, correlations between infant mortality and births to teenagers ranged from .85-.95; between infant mortality and low birth weight from .91-.97; and between births to teenage mothers and low birth weight infants, .96-.97. (Table II)

These two variables followed patterns similar to predicted infant mortality rates for 53 of the 76 community areas. For 22 areas, both births to teens and low birth weight infants fell into the same risk category as infant mortality; for 19 areas, low birth weight was in the same category as infant mortality, and for 13 areas, births to teens fell into the same category as infant mortality. Of the remaining 23 communities, 11 communities were still within the predicted range for infant mortality (having been explained by socioeconomic and demographic data), 6 could not be assigned to a risk category because of fluctuating data, while 3 were in the lower than predicted category and 2 were in the higher than predicted category. (Tables III and IV)

In 4 of the 6 areas where infant mortality was higher than predicted (III-IM-P), higher than predicted rates of births to teenagers or low birthweight offer possible explanations. One area was explained by low birth weight, two areas were accounted for by births to teenage mothers, and in another area, both birth to teenage mothers and low birth weight explained its rate of infant mortality.

Moreover, 9 of the 11 lower than predicted risk areas for infant mortality (I-IM-P) may be explained by lower than predicted rates of teen births or low birthweight (I-TB-P and I-LBW-P). Two of these lower than predicted infant mortality areas also had both lower than predicted births to teens and low birthweight rates, while four areas fell in the lower than predicted teen birth category, and 3 fell in the lower than predicted low birth weight category.

For example, two adjacent communities Avalon Park (area #45) and Burnside (area #47) have similar socioeconomic and demographic variables, (e.g. 88-96% black, 32-40% female headed homes, 10-15% below poverty level) and fall into the high actual risk category. However, Avalon Park has infant mortality rates which place it in the lower than predicted risk category while Burnside is in the higher than predicted risk group. Thus, although both communities have some of the highest infant mortality rates in the city, Avalon Park's rate "should be" even higher, while Burnside's "should be" even lower given their demographic and socio-economic characteristics.

Both deviations from the predicted range may be attributed to the pattern of rates of births to teenage mothers, with lower than predicted rates in Avalon Park and higher than predicted rates in Burnside.

Avalon Park (Area 45)

	Actual IM	Predicted IM	Actual TB	Predicted TB
1980	27.2	17.4-30.2	22.8	19.8-24.8
1981	55.0	26.8-40.4	17.5*	18.0-22.6
1982	16.3*	18.1-26.5	24.5	17.9-23.1
1983	15.9*	18.8-29.6	14.8*	17.7-23.1
1984	11.3*	13.9-22.7	20.3	17.8-22.5
1985	26.0	15.9-29.9	14.6*	17.0-21.8

Burnside (Area 47)

	Actual IM	Predicted IM	Actual TB	Predicted TB
1980	49.4*	26.5-42.5	32.1*	21.0-28.4
1981	49.4*	20.8-38.0	22.2	18.7-24.5
1982	26.3	19.7-30.5	22.4	16.8-23.4
1983	15.2	17.1-30.7	30.3*	18.2-25.0
1984	14.5	14.2-25.4	36.2*	20.6-26.8
1985	63.3*	25.2-42.8	31.7*	20.1-26.5

Four other communities adjacent to each other on the northwest side of Chicago are in different risk categories for infant mortality, and require different explanations. The communities of Montclare (area #18) and Hermosa (area #20), fall into the category of higher than predicted risk for infant mortality. Both communities reflect instability in terms of actual rates: Montclare falls into the low risk category for 3 of the 6 years and into the high risk category for the other 3 years. Hermosa has rates in the low, average, and high risk categories for two years each. In Montclare, higher than predicted infant mortality rates can be attributed to higher than predicted low birth weight rates, while Hermosa's higher than predicted infant mortality rates can be attributed to higher than predicted rates of births to teenage mothers.

Montclare (Area 18)

	Actual IM	Predicted IM	Actual LBW	Predicted LBW
1980	28.3*	11.1-19.5	3.8	5.0 - 6.4
1981	20.4*	9.7-18.5	9.2*	5.1 - 6.7
1982	9.2	5.7-11.3	7.3*	5.8 - 7.2
1983	31.6*	8.6-15.6	4.2	5.0 - 6.4
1984	0	6.7-12.5	9.4*	5.5 - 6.9
1985	0	1.8-10.8	6.1	4.6 - 6.4

Hermosa (Area 20)

	Actual IM	Predicted IM	Actual TB	Predicted TB
1980	24.2*	9.4-19.4	19.9*	11.6 - 16.2
1981	10.5	6.3-16.9	14.4	12.2 - 15.8
1982	14.5	10.3-17.1	14.2	10.4 - 14.4
1983	16.1*	6.5-14.8	14.5*	10.0 - 14.2
1984	8.1	10.5-17.3	14.9*	11.0 - 14.8
1985	21.3*	6.1-16.9	11.4	9.9 - 13.7

The communities of Dunning (area 17) and Belmont Cragin (area 19), are similar in socioeconomic and demographic makeup, (e.g. both 90% white, 10-15% female headed households, and 3-4% below poverty level) and both have low actual rates and lower than predicted rates for infant mortality. In Dunning, the infant mortality rate can be explained by a lower than expected birth rate to teens. However, Belmont Cragin is an anomaly as the teen birth rate as well as the low birthweight rate are within the predicted range and thus do not explain this area's higher than predicted infant mortality rate. One possible explanation is the high proportion of participation in prenatal education classes by expectant mothers at a nearby hospital where the maternity ward nurse reported that over 90% of mothers delivering at this hospital participate in the program. However, further investigation is needed to determine other possible sources of enrichment to the community which would also have a positive effect on infant mortality rates.

Dunning (Area 17)

	Actual IM	Predicted IM	Actual TB	Predicted TB
1980	9.4	10.4 - 18.0	4.1*	6.3 - 9.7
1981	8.7*	9.0 - 17.0	6.4*	7.1 - 9.9
1982	2.9*	4.6 - 9.8	7.5	6.2 - 9.2
1983	2.4*	7.2 - 13.6	3.8*	4.5 - 7.7
1984	8.1	5.5 - 10.7	2.6*	4.9 - 7.9
1985	12.8	1.4 - 9.8	2.1*	3.8 - 6.8

Belmont Cragin (Area 19)

	Actual IM	Predicted IM	Actual TB	Predicted TB	Actual LBW	Predicted LBW
1980	9.6	13.3-21.3	9.4	8.0-11.6	5.6	5.6-7.0
1981	4.7*	8.7-17.1	7.4	8.4-11.2	4.7	4.8-6.4
1982	6.2*	7.5-12.7	6.4	6.5-9.7	4.7	5.7-7.1
1983	7.6	7.4-14.2	6.3	5.7-8.9	6.5	5.0-6.4
1984	7.3*	7.9-13.5	7.0	6.7-9.7	6.2	5.7-7.1
1985	6.0	4.3-13.1	8.3	5.6-8.6	9.2	3.8-5.8

DISCUSSION

For communities not explained by the above socio-economic and demographic variables included in the multiple regression analysis, or the additional factors of low birth weight and births to teens, we can turn to idiosyncratic community level factors that may account for the findings.

Three additional communities were anomalies, not explained either by the nine demographic and socioeconomic variables, or by rates of teen births or low birth weights. Two of these communities, West Elsdon (area 62) and Grand Boulevard (area 38) were in the high risk category (III-IM-P) and one, Chicago Lawn (area 66), was in the low risk category (I-IM-P).

While the two communities of West Elsdon and Chicago Lawn lie near each other in the southwest part of Chicago, and show similar socioeconomic and demographic characteristics (e.g., +80% white, 13-18% female headed households, median education level of

12.1, and $21,000-$23,000 median income) they exhibit very different profiles in terms of infant mortality, births to teenagers, and low birthweight infants. Although West Elsdon had low actual infant mortality rates, these rates were nevertheless higher than expected despite lower than predicted rates of births to teens and low birthweight infants (III-IM-P, I-TB-P, I-LBW-P).

West Elsdon (Area 62)

	Act IM	Pred IM	Act TB	Pred TB	Act LBW	Pred LBW
1980	52.6*	12.1-19.7	4.6*	6.9-10.3	7.2	5.2-6.3
1981	7.5	9.1-17.1	10.5	7.8-10..5	4.5*	5.1-6.5
1982	8.0	5.9-11.1	4.8*	6.5-9.5	4.8*	5.7-7.1
1983	37.9*	7.1-13.5	5.3	4.7-7.9	8.3	4.8-6.2
1984	15.3*	6.9-12.1	9.9	5.8-8.8	3.8*	5.5-6.9*
1985	7.9	2.8-11.2	3.2*	4.4-7.4	3.2*	4.6-6.2

Conversely, Chicago Lawn had lower than expected infant mortality rates, (although actual rates were in the middle category), despite higher than predicted rates of births to teens (I-IM-P, III-TB-P).

Chicago Lawn (Area 66)

	Actual IM	Predicted IM	Actual TB	Predicted TB
1980	12.4*	12.9-20.5	15.8*	9.8-13.2
1981	9.3*	9.7-17.7	14.7*	10.2-13.0
1982	22.9	9.9-15.1	12.2*	8.9-12.1
1983	14.9	9.7-16.1	12.4*	8.5-11.7
1984	6.3*	9.6-14.8	11.4	8.6-11.6
1985	9.2	8.8-16.9	10.4	8.2-11.2

In developing a hypothesis to account for this discrepancy we turn to local history. Chicago Lawn has been undergoing transition over the past decade (since the 1980 census). Primarily a working class, second and third generation eastern European community, it has seen an influx of black, hispanic and Arab populations in part of the area. This demographic change could explain the higher than expected teen birth rate (black and hispanics have higher teen birth rates in other Chicago communities). But the area's status as low risk for infant mortality requires explanations beyond simple demography. One possibility suggested by an informal interview with a nurse on the maternity ward of a large community hospital in the area, is the utilization of parenting education and support programs by new mothers around the time of birth.

West Elsdon displays the only pattern of higher than risk for infant mortality and lower than predicted risk for both births to teens and low birthweight infants (III-IM-P; I-TB-P I-LBW-P) out of 76 cases. In this community, infant mortality is not associated with socioeconomic or demographic patterns, or with births to teens or low birth weight. Even though the area's actual infant mortality rates are low for 3 years (7.5, 8.0 7.9) average for 1 year (15.3) and high for 2 years (52.6, 37.9) when compared to Chicago's overall rate, these actual infant mortality rates are still higher than what "should be" given its socioeconomic and demographic profile and in terms of its low rates of births to teens and low birth weight infants.

West Elsdon is characterized by a large older population (i.e., 18% are 65 years or older compared to a city average of 11%; the median age is 44 compared to a citywide average of 29). This can explain the area being at low risk for teen births and low birthweight, but it does not explain its status as an area at high risk for infant mortality. Rather, older maternal age and infants who are of normal birthweight--factors which would be associated with low infant mortality--are in this case associated with high infant mortality. A possible explanation for this phenomenon derives from the fact that the only hospital in the area closed in 1975 and was never replaced, a presumed effect of which is a lack of prenatal care and parent education programs. This, in contrast with the Belmont Cragin and Chicago Lawn situation discussed earlier, strongly suggests that we are observing the effect of negative institutional policy and practice at work in the social environment for child bearing.

The other high risk community with higher than predicted rates, Grand Boulevard, was the only community in this study which had both one of the city's highest actual rates of infant mortality (ranging from 21.5 to 32.8 over this six year period) as well as rates that were even higher than would be predicted for such an impoverished community. Although the rates of births to teens and low birth weight infants are among the highest in the city, Grand Boulevard is still within the predicted range for these two variables.

Grand Boulevard (Area 38)

	Actual	Predicted	Actual	Predicted	Actual	Predicted
	IM	IM	TB	TB	LBW	LBW
1980	32.8*	14.2-31.0	39.4	36.0-42.6	16.6	14.7-17.9
1981	26.0	11.4-29.0	37.8	33.1-39.1	17.2	15.2-18.4
1982	22.7	19.8-31.0	36.2	35.0-41.8	18.3	15.6-18.6
1983	30.0*	15.2-29.2	36.7	34.8-41.7	17.5	15.2-18.2
1984	21.5	18.4-30.0	35.9	31.5-37.9	16.4	14.5-17.5
1985	29.0*	7.6-26.0	35.5	31.6-38.2	14.7	12.5-16.1

This high rate of infant mortality is not adequately explained by demographic or socioeconomic factors, teen births, or rate of low birthweight. This leads us again to local history for an idiosyncratic explanation.

One factor to consider in Grand Boulevard is the atypically high rate of Sudden Infant Death Syndrome (SIDS). 32.4% of all infant mortality deaths in Grand Boulevard in 1983 was diagnosed as SIDS compared to 20.9 for Chicago and 12.4 for the nation. Research has indicated that such abnormally high rates of SIDS may be due to unrecognized maltreatment, accidents, or neglect (Bass, 1986).

In a study by Zumwalt and Hirsch, (198) only 15-20% of children who died by violence showed any external injuries. Careful investigations of "unexplained" (SIDS) deaths often showed physical abuse as the cause. Additional "unexplained" causes of infant mortality due to physical neglect included exposure to a dangerous environment, failure to provide medical care when needed, and exacerbation of natural disease by neglect.

Another factor for consideration is atypically high rates of child homicide in an area. In a study of child homicides in Cook county, Cristoffel found that all homicides occurred in only 22% of the county's census tracts. Additionally, there were almost as many deaths labeled "undetermined" which were more probably homicide cases, as there were deaths labeled homicide (Cristoffel, 1987). The underreporting of homicides is due to insufficient evidence, negligence by medical examiners, and the reluctance or unwillingness of reporters to consider homicide a diagnosis (Jason, 1983).

Because Grand Boulevard also has one of the highest child abuse and neglect rates in Chicago (13.5 per 1000 in 1980), the higher infant mortality rate could reflect its higher rates of unidentified child abuse and neglect. Other research has determined that infants from physically abusing families are at greater risk of death, though not necessarily by physical abuse (Creighton, 1980; Roberts, 1980). The "unexplained" infant mortality may be attributed to a social environment that has deteriorated even further than the already sad socioeconomic and demographic data indicate. Informal observations and discussions with expert informants tend to support this view.

CONCLUSION

This study sheds light on the human ecology of infant mortality by highlighting the interplay of social systems in the experience and development of infant human organisms. It demonstrates two distinct meanings of high risk, and documents the role of socioeconomic and demographic correlates in establishing a community's level of risk as an environment for children. It further identifies communities that require idiosyncratic, "historical" explanations beyond simple socioeconomic and demographic profiling. Thus it contributes to our understanding of the human ecology of early childhood.

TABLE I

CORRELATIONS FOR INFANT MORTALITY, BIRTHS TO TEENAGE MOTHEERS, AND LOW BIRTHWEIGHT INFANTS WITH DEMOGRAPHIC AND SOCIOECONOMIC VARIABLES

	Infant Mortality	Teen Births	Low Birthweight Infants
1980	.59	.94	.91
1981	.67	.96	.94
1982	.83	.95	.92
1983	.69	.95	.94
1984	.78	.95	.93
1985	.70	.95	.91

TABLE II

CORRELATIONS BETWEEN INFANT MORTALITY, BIRTHS TO TEENAGE MOTHERS, AND LOW BIRTHWEIGHT INFANTS

	Infant Mortality/ Teen Births	Infant Mortality/ Low Birthweight	Teen Births/ Low Birthweight
1980	.92	.97	.97
1981	.85	.91	.96
1982	.93	.97	.97
1983	.94	.96	.97
1984	.95	.95	.97
1985	.89	.92	.96

TABLE III

PATTERNS OF PREDICTED HIGH RISK, PREDICTED LOW RISK, AND WITHIN PREDICTED RANGE FOR INFANT MORTALITY, BIRTHS TO TEENAGERS AND LOW BIRTHWEIGHT INFANTS

I - Stably Low Risk for at least 3 out of 6 years

II - Stably Within Predicted Range for at least 3 out of 6 years

III - Stably High Risk for at least 3 out of 6 years

Infant Mortality	Teen Births	Low Birth-Weight	Number of Communities With This Pattern
II	II	II	19
II	I	II	9
II	III	II	6
II	II	III	6
II	III	III	4
II	I	I	3
I	I	II	3
I	II	I	3
I	I	I	2
II	III	I	2
III	II	II	1
I	II	II	1
I	III	III	1
III	I	I	1
III	I	III	1
III	III	I	1
III	III	II	1
III	III	III	1
I	I	III	0
I	II	III	0
I	III	I	0
I	III	II	0
II	II	I	0
II	I	III	0
III	I	II	0
III	II	I	0
III	II	III	0

TABLE IV

PATTERNS OF INFANT MORTALITY, BIRTHS TO TEENS, AND LOW BIRTHWEIGHT BY COMMUNITY AREA

I - Stably Low Risk for at least 3 out of 6 years

II - Stably Within Predicted Range for at least 3 out of 6 years

III - Stably High Risk for at least 3 out of 6 years

Area	Infant Mortality	Teen Births	Low Birth-Weight
1	II	II	II
2	II	I	II
3	II	II	II
4	II	I	II
5	II	II	II
6	II	II	II
7	II	II	II
8	II	III	II
9	I	I	I
10	I	I	II
11	I	I	I
12	II	I	II
13	I	II	I
14	II	II	III
15	II	II	II
16	--	II	II
17	I	I	II
18	III	I	III
19	I	II	II
20	III	III	II
21	II	II	II
22	II	II	II
23	II	III	II
24	II	II	II
25	II	II	III
26	II	III	II
27	II	II	III
28	II	II	II
29	II	II	II
30	II	I	II
31	II	I	II
32	--	I	II
33	II	I	I

Area	Infant Mortality	Teen Births	Low Birth-Weight
34	II	II	II
35	II	II	II
36	II	II	II
37	II	III	I
38	III	II	II
39	II	II	II
40	--	III	III
41	II	I	II
42	II	I	II
43	II	I	II
44	--	I	II
45	I	I	II
46	II	I	I
47	III	III	I
48	II	II	II
49	II	III	III
50	I	I	--
51	II	II	III
52	II	III	--
53	--	III	II
54	II	II	II
55	II	III	III
56	II	III	III
57	I	II	I
58	III	III	III
59	II	III	--
60	II	III	II
61	II	III	II
62	III	I	I
63	II	II	--
64	I	II	I
65	II	II	III
66	I	III	III
67	II	III	II
68	II	III	I
69	II	I	I
70	II	II	II
71	II	II	III
72	--	II	I
73	II	III	--
74	II	I	II
75	II	III	III
76	II	II	II

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